



2017

A Mental Health Checkup for Children at the Doctor's Office: Lessons from the Medical-Legal Partnership Movement to Fulfill Medicaid's Promise

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Yale Journal of Health Policy, Law and Ethics, Vol. 17, Issue 2, 253.

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ARTICLES

A Mental Health Checkup for Children at the Doctor's Office: Lessons from the Medical-Legal Partnership Movement to Fulfill Medicaid's Promise

Yael Cannon*

ABSTRACT

Traumatic childhood events and the stress they cause can negatively affect health over a lifetime. For children with Medicaid coverage, visits to the doctor's office present an opportunity to improve this trajectory. Medicaid's Early Periodic Screening Diagnostic and Treatment (EPSDT) mandate requires that children receive more than a basic physical when they see a doctor for regular "well-child checks." As part of a comprehensive look at their development, they should receive mental health check-ups that could identify childhood trauma, its impacts, and the interventions that could help improve health and mental health. Data suggests that many children do not receive these mandatory comprehensive screenings. Significant barriers to screening include lack of transportation for patients, low reimbursement rates for physicians that limit their ability to devote enough attention to screenings, and lack of access to mental health screening tools.

Medical-legal partnerships (MLPs) provide a framework for addressing these challenges. MLPs bring together civil legal services lawyers with health providers to address social determinants of health. This article argues that the MLP movement provides a three-tiered paradigm for change for physicians and attorneys to improve the trajectory for children who have suffered trauma and address the gaps in Medicaid EPSDT mental health screening: (1) collaborative advocacy to improve patient health, (2) transformation of health and legal institutions, and (3) policy change.

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INTRODUCTION

Selena¹ was born addicted to “meth.” Her mother, Amelia, tried hard to get sober when she found out she was pregnant, but was not successful and Selena was exposed to methamphetamine in utero. Amelia ended up in a detox facility shortly after Selena was born, while Selena’s father was in prison. Fortunately, Selena recovered quickly. After a few weeks, she was discharged from the neonatal intensive care unit into the care of Amelia’s sister, Joann, while Amelia completed her detox program. Over the next couple of years, Selena bounced back and forth between her mother’s and her Aunt Joann’s home. Amelia’s boyfriend was abusive to her in front of Selena, and when things got really bad, Amelia would drop Selena off at Joann’s house. When Selena was two and a half years old, Amelia told Joann she needed to take some time to get her life together and asked Joann to care for Selena for a while. Amelia disappeared and never returned.

At age thirteen, Selena is struggling. She often feels anxious and struggles academically. Since school is so difficult for her, she regularly skips it and hangs out at a park where she smokes marijuana. She feels sad when she thinks about her mother, which is frequently. She eats to make herself feel better, and is now significantly overweight. Otherwise, Selena seems healthy. When she goes to the doctor, he talks to her about eating healthier, but gives her a clean bill of health. Joann is doing her best to keep Selena out of trouble.

Traumatic events in childhood like those experienced by Selena are known as adverse childhood experiences, or ACEs. One of the most groundbreaking epidemiological studies in our nation’s history demonstrated the high prevalence of ACEs, with more than half of the study’s respondents reporting at least one traumatic event in childhood.² The ACEs study also revealed that children who experience these forms of trauma early in life are more likely not only to experience mental health challenges, but also to face a multitude of poor health issues.³ Trauma like that experienced by Selena can actually change the brain and make the body unhealthy.⁴ This article begins in Part I by dissecting the implications of childhood trauma on an individual’s health and the types of mental health services that children with these experiences require.

Although the research paints a dire picture, it also shows that the fate it predicts for a child such as Selena can in fact be disrupted. With early identification of trauma and related mental health needs, a child and her family can gain access

1. Selena and her family are a composite of clients commonly served by the University of New Mexico Medical Legal Alliance. *See infra*, described in Part III of this article.

2. *See* Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction of Many of the Leading Causes of Death in Adults*, 14 AM. J. PREVENTIVE MED. 245, 249 (1998).

3. *See id.* at 251.

4. *See* Jack P. Shonkoff et al., *Technical Report: The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS e232, e236–37 (2012).

to needed services and have a chance to experience a healthy life.⁵ In Part II, the article argues that the sweeping national Medicaid program, through which children living in poverty have access to health and mental health care,⁶ provides a structure for this critical early identification and intervention to facilitate better outcomes for traumatized children.⁷ Medicaid law requires mental health screening and necessary treatment for all Medicaid-eligible children. In fact, the Early Periodic Screening Diagnostic and Treatment (EPSDT) mandate in federal Medicaid law and the accompanying regulations promulgated by the U.S. Department of Health and Human Services require mental health screenings as part of routine visits to the doctor, as well as referral to services that may be necessary to address identified issues.⁸ This article argues that mental health screenings in the doctor's office have the potential to improve the health and mental health outcomes of many children who experience trauma in early childhood because they provide a gateway to needed services that can improve a child's life trajectory.

However, Medicaid-enrolled children do not always receive mandated mental health screenings as part of their doctor's visits,⁹ evidencing a missed opportunity

5. See Hillary A. Franke, *Toxic Stress: Effects, Prevention, and Treatment*, 1 CHILDREN 390, 394 (2014) ("If primary preventive measures are implemented during the early, sensitive windows of development, appropriate stress responses to adversity may result. Screening is a means to identify those children who would benefit from both preventive measures and, if need be, therapeutic interventions.").

6. See 42 U.S.C. §1396a(a)(43) (2012).

7. See 42 U.S.C. §1396d(r) (2012) (Requiring, at minimum, a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, and health education).

8. See *id.*

9. See, e.g., Health Res. & Servs. Admin., *The Health and Well-Being of Children: A Portrait of States and the Nation 2011-2012*, U.S. DEP'T HEALTH & HUM. SERVS. 22 (2014), <https://mchb.hrsa.gov/nsch/2011-12/health/pdfs/nsch11.pdf> [https://perma.cc/3P9L-5384] [hereinafter *Well-Being of Children*] (reporting results of the 2011–2012 National Survey of Children's Health, which found that only 31.5% of publicly insured children nationwide received a standardized developmental or behavioral health screening between the ages of ten months and five years). At the time of publication of this article, the legislative landscape remains in flux, with members of Congress having introduced multiple legislative proposals in recent months seeking to change the current Medicaid funding structure as part of Republican efforts to repeal and replace the Affordable Care Act. In two of the most significant bills, the American Health Care Act (AHCA) and the Graham-Cassidy proposal, Medicaid was targeted for restructuring. American Health Care Act of 2017, H.R. 1628, 115th Cong. (1st Sess. 2017); Graham-Cassidy-Heller-Johnson Proposed Amendment to H.R. 1628, H.R. 1628, 115th Cong. (1st Sess. 2017). Although neither the Act nor the proposal explicitly repeals or amends the EPSDT provisions, it proposes financial restructures that potentially jeopardize the continued comprehensiveness and robustness of Medicaid-based pediatric healthcare. Current EPSDT benefits require states to provide four screenings – medical, vision, dental, and hearing – and all "other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan" to Medicaid-eligible persons in the state who are under the age of twenty-one. 42 U.S.C. §1396d(r) (2012); 42 U.S.C. §1396a(4)(B) (2012). Under the proposed AHCA and Graham-Cassidy bills, federal contributions towards benefits for children under 19 years old who are not covered under the

for early identification of trauma, as well as the resulting connections to needed services. While more research is needed to understand the reasons behind these gaps, some barriers have been identified by physicians and patients. In Part III, the article calls physicians and attorneys to action to ensure that children who have suffered trauma are identified early and receive the mental health services they need to cope with that trauma effectively and thrive. Medical-legal partnerships (MLPs) provide a framework for concrete steps that lawyers and healthcare professionals can take together to change the trajectory from childhood trauma to poor health through patient services, institutional change, and policy change.

MLPs bring together lawyers and doctors who serve people living in poverty to address legal barriers to health in individual patients and improve systemic

Children's Health Insurance Program (CHIP) would be restructured as per capita caps with a block grant option. H.R. 1628 §121(2) (proposing introduction of new §1903A to Title XIX of the Social Security Act). Children are one of only two Medicaid enrollee populations subject to the block grant option. *Id.* In opposing the AHCA, the American Academy of Pediatrics (AAP) argued that this proposed restructuring would divert costs to the states. Letter from Fernando Stein, President, Am. Acad. Pediatrics, to Chairman Kevin Brady, Chairman Greg Walden, Ranking Member Richard Neal, and Ranking Member Frank Pallone (Mar. 8, 2017), <https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Documents/AAP%20Letter%20Opposing%20AHCA.pdf> [https://perma.cc/B9BQ-GFBT] [hereinafter AAP Opposition Letter]. Given the already low per-person costs, these changes are unlikely to lead to improvements in Medicaid efficiency, but instead could require states to either increase state contributions or implement changes in the scope of coverage, including "reductions in enrollment, cuts to benefits, and decreased access to physicians." *Id.*; Ctr. for Children & Families, *How Restructuring Medicaid Could Affect Children*, GEO. U. HEALTH POL'Y INST. 2 (Feb. 2017), <http://ccf.georgetown.edu/wp-content/uploads/2017/02/Medicaid-funding-caps.pdf> [https://perma.cc/5CAE-YXDC]. Potential consequences of increased spending include cuts to other child and family services such as childcare, education, child welfare, juvenile justice, and family support programs. *Id.* at 3. Since neither the AHCA nor the Graham-Cassidy proposal mentions or cites the current EPSDT requirements, it is unclear whether states could elect to cut these services. Indeed, under the AHCA and the Graham-Cassidy proposal's block grant option, the state plan must merely provide for "health care for children under 18 years of age." H.R. 1628 §121(2). This ambiguous standard creates a potential for reductions in screening, diagnosis, and access to treatment, and more variation in interpretation across states. Mara Youdelman & Jane Perkins, *AHCA's Block Grant Option and EPSDT*, NAT'L HEALTH L. PROGRAM 3 (2017), <http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00P0W00000jYT KjUAO> [https://perma.cc/B9R7-ADVK]. Both the AHCA and the Graham-Cassidy proposal failed to pass Congress. See Phil Mattingly, *GOP Takes Stock After Another Health Care Failure*, CNN (Sept. 26, 2017, 6:10 AM), <http://www.cnn.com/2017/09/26/politics/health-care-what-next/index.html> [https://perma.cc/6SSU-NTR9]. However, Medicaid restructuring appears to be a priority of the current Republican majority in Congress. Another concern articulated by the AAP in connection with such efforts is the phasing out of a provision of the Affordable Care Act that expanded Medicaid eligibility to more than half a million children from low-income families. According to the AAP, eliminating this provision can result in a confusing constellation of coverage within a family with different coverage under different programs for different family members. See AAP Opposition Letter. If additional legislative proposals emerge from Congress that propose restructuring Medicaid or eliminating the prior expansion of Medicaid under the Affordable Care Act, analysis to determine both the impact on both the substantive Medicaid EPSDT legal requirements and the availability of Medicaid to low-income children and children with disabilities will be critical.

conditions facing patient populations. In 1993, Dr. Barry Zuckerman, a pediatrician at Boston Medical Center, realized that he could not get his patients healthy without a lawyer.¹⁰ He was treating children with asthma who would cycle in and out the emergency room, suffering repeated asthma attacks despite receiving high quality medical care. He learned that many of these children were living in substandard housing conditions, where mold and dust mites were exacerbating their asthma.¹¹ He could not care for those patients effectively or get them healthy without an attorney who could advocate with landlords and public housing programs for improvements in their housing conditions.¹² Dr. Zuckerman brought a lawyer onto his team, giving rise to the medical-legal partnership (MLP) movement, which recognizes that medicine and law can operate collaboratively and preventively in service of patients and population health.¹³ MLPs have mobilized to create an impact on three levels: (1) collaborative advocacy to improve patient health; (2) transformation of health and legal institutions; and (3) policy change.¹⁴ These tiers provide a paradigm through which attorneys and healthcare providers can serve as catalysts for change. With over half of the ACEs study population having reported a traumatic experience in childhood and one-fourth reporting two or more ACEs,¹⁵ physicians and attorneys can improve outcomes for a significant portion of the next generation if they similarly mobilize through a multi-level response to ensure that childhood trauma is identified and the resulting health and mental health needs of children are addressed.

10. See Jane R. Wettach, *The Law School Clinic as a Partner in a Medical-Legal Partnership*, 75 TENN. L. REV. 305, 307 (2008).

11. See Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224, 224–25 (2004).

12. See *id.*

13. See Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations*, 29 HEALTH AFF. 1697, 1698 (2010).

14. *The MLP Response*, NAT'L CTR. MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/mlp-response> [https://perma.cc/VR5T-XAX4] [hereinafter *The MLP Response*]. As discussed by Elizabeth Tobin Tyler, a tension between individual service and social change advocacy can sometimes be seen in the legal services community, perhaps due to the fact that organizations receiving Legal Services Corporation (LSC) funding are restricted from certain activities that are historically construed as drivers of systemic change (such as class action lawsuits and legislative lobbying). Limited resources also require some legal services organizations to keep their efforts focused on individual direct services legal representation. Therefore, some legal services providers may not engage in social policy change work as a focused effort. However, Tobin Tyler argues that when possible, legal services professionals, in collaboration with clinical and public health professionals can and should embrace an integrated approach to changing system and policy factors that affect vulnerable patients. Her recommendations include identifying social, legal, and health needs as well as tracking unmet need for the purposes of achieving social policy change. See Elizabeth Tobin Tyler, *Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health*, 8 J. HEALTH & BIOMEDICAL LAW 211, 239 (2012).

15. See Felitti et al., *supra* note 2, at 245.

I. EFFECT OF CHILDHOOD TRAUMA ON HEALTH

Selena has a strong likelihood of becoming an unhealthy adult. While it may seem intuitive that a person who experiences childhood trauma like Selena may struggle with mental illness or substance abuse later in life, a growing body of research over the past three decades has shown that childhood adversity actually takes a toll on the entire body.¹⁶ Exposure to certain categories of traumatic events—ACEs¹⁷—is associated with increased risk for numerous chronic physical health conditions, mental illness,¹⁸ and even early death.¹⁹ Those poor health effects can begin in childhood.²⁰

A. The ACEs Study

In the late 1990s, researchers working with the U.S. Centers for Disease Control and Prevention and the Kaiser Family Foundation conducted a groundbreaking study of the connection between childhood exposure to emotional, physical, and sexual abuse, as well as household dysfunction and subsequent adult health risk behaviors and disease.²¹ Over an eight-month period,²² researchers mailed questionnaires to 13,949 Kaiser Health Plan members who visited the Health Appraisal Clinic.²³ This clinic served the general population of Kaiser patients, who did not present as a population with any particular likelihood of childhood trauma history. Each survey included questions about childhood abuse, including psychological, physical abuse, and sexual abuse, and questions about household dysfunction they experienced in childhood, including substance abuse, mental illness, and incarceration of a household member, as well as violence

16. See Katherine B. Ehrlich et al., *Childhood Adversity and Adult Physical Health*, in DEVELOPMENTAL PSYCHOPATHOLOGY: RISK, RESILIENCE, AND INTERVENTION 1, 4–12 (Dante Cicchetti ed., 3d ed. 2016).

17. See Felitti, *supra* note 2.

18. See, e.g., Daniel P. Chapman et al., *Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood*, 82 J. AFFECTIVE DISORDERS 217, 222–23 (2004); Shanta R. Dube et al., *Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span*, 286 J. AM. MED. ASS'N 3089, 3094–95 (2001); Charles L. Whitfield et al., *Adverse Childhood Experiences and Hallucinations*, 29 CHILD ABUSE & NEGLECT 797, 803 (2005).

19. See David Brown et al., *Adverse Childhood Experiences and the Risk of Premature Mortality*, 37 AM. J. PREVENTIVE MED. 389, 393 (2009) (finding a relationship between risk of death at any age and ACE scores greater than or equal to six).

20. See, e.g., Nadine J. Burke et al., *The Impact of Adverse Childhood Experiences on an Urban Pediatric Population*, 35 CHILD ABUSE & NEGLECT 408, 412–13 (2011); Emalee G. Flaherty et al., *Adverse Childhood Experiences and Child Health in Early Adolescence*, 167 JAMA PEDIATRICS 623, 626 (2013).

21. See Felitti et al., *supra* note 2, at 246.

22. Questionnaires were sent to members who visited the clinic between August and November of 1995 and January and March of 1996. Those seen in December were excluded. *Id.*

23. *Id.* Response rate was 70.5 percent; 9,508 completed the questionnaire. *Id.*

against the patient's mother.²⁴

The patients, most of whom were over fifty years old, were asked to reflect on events in their childhood.²⁵ More than half of the patients surveyed reported experiencing at least one form of childhood trauma.²⁶ The prevalence of specific forms of trauma among the respondents was also surprisingly high:

- 11.1 percent reported psychological abuse;
- 10.8 percent reported physical abuse;
- 22.0 percent reported sexual abuse;
- 25.6 percent reported substance abuse by a household member;
- 18.8 percent reported mental illness of a household member;
- 12.5 percent reported violence directed against their mother or stepmother; and
- 3.4 percent reported incarceration of an adult household member.²⁷

The reach of trauma among this general population cohort²⁸ is astounding; *more than a quarter* had a household member who engaged in substance abuse, and *more than one in five* recalled having experienced sexual abuse.²⁹ Some individuals experienced multiple traumatic events, reflected by their total ACE score, in which each experience counts as one ACE.³⁰ Using this framework, Selena experienced multiple ACEs. She was exposed to methamphetamine in utero and born with the drug still in her system, meaning that she has a parent who was a substance abuser. Her father was incarcerated, and she witnessed violence against her mother. By the age of two and a half, Selena already had an ACE score of at least three.

The Kaiser/CDC researchers sought to understand the implications of a person's ACE score. They examined the medical records of the patients and analyzed the relationship between the patients' ACE scores and the likelihood of certain disease conditions and health risk factors. They found that high ACE scores, especially where patients had four or more ACEs, were correlated with poor health conditions and behaviors, such as increased risk of ischemic heart

24. *Id.* at 248 tbl.1.

25. *Id.* at 247.

26. *Id.* at 248 tbl.1.

27. *Id.*

28. See, e.g., Michael T. Baglivio et al., *The Prevalence of Adverse Childhood Experiences in the Lives of Juvenile Offenders*, 3 J. JUV. JUST. 1, 1–23 (comparing the prevalence of ACEs among juvenile offenders in Florida to the general population group analyzed in the original Kaiser study); Yael Cannon et al., *Adverse Childhood Experiences in the New Mexico Juvenile Justice Population*, N.M. SENT'G COMMISSION 4 (2016), <https://nmssc.unm.edu/reports/2016/adverse-childhood-experiences-in-the-new-mexico-juvenile-justice-population.pdf> [<https://perma.cc/WV9G-VK56>] (comparing the prevalence of ACEs among youth in custody in New Mexico's juvenile justice population to the general population group analyzed in the original Kaiser/CDC ACEs study).

29. Felitti et al., *supra* note 2, at 248 tbl.1

30. *Id.* at 248.

disease,³¹ cancer,³² stroke,³³ chronic bronchitis or emphysema,³⁴ diabetes,³⁵ fair or poor self-rated health,³⁶ self-diagnosed alcoholism,³⁷ illicit drug use,³⁸ injectable drug use,³⁹ and sexual promiscuity.⁴⁰ Selenia's score of three ACEs by age two and a half set her on a path toward potentially devastating health and mental conditions over her lifetime.

The ACEs study has prompted interest in the connection between childhood trauma and poor health outcomes, both among health researchers and increasingly in the media and broader public health discussions.⁴¹ The current body of literature in the ACEs field contains more than 450 follow-up studies and publications.⁴² Evidence now links ACEs to an increased risk of hospitalization with a diagnosed autoimmune disease,⁴³ chronic obstructive pulmonary disease,⁴⁴ and liver disease.⁴⁵ In addition, ACEs have been associated with an increased risk of depressive disorders,⁴⁶ hallucinations,⁴⁷ and suicidality in adults.⁴⁸ These studies show that the entire body can suffer during adulthood as a result of childhood trauma.

Moreover, the research is increasingly drawing connections between childhood trauma and poor physical and mental health in childhood.⁴⁹ As part of

31. *Id.* at 254 tbl.7.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.* at 255 tbl.8.

37. *Id.* at 253 tbl.5.

38. *Id.*

39. *Id.*

40. *Id.*

41. See, e.g., Laura Starcheski, *Can Family Secrets Make You Sick?*, NAT'L PUB. RADIO (Mar. 2, 2015, 3:02 PM), <http://www.npr.org/sections/healthshots/2015/03/02/377569413/can-family-secrets-make-you-sick> [<https://perma.cc/54LJ-2968>]; *Adverse Childhood Experiences: A Collection of News, Perspectives, and Other Resources to Help Raise Awareness, Prevent ACEs, and Improve Resiliency*, ROBERT WOOD JOHNSON FOUND., <http://www.rwjf.org/en/library/collections/aces.html>.<http://www.rwjf.org/en/library/collections/aces.html> [<https://perma.cc/5EJ3-NEZ9>].

42. Yael Cannon & Andrew Hsi, *Disrupting the Path from Childhood Trauma to Juvenile Justice: An Upstream Health and Justice Approach*, 43 FORDHAM URB. L. J. 425, 445 (2017).

43. See Shanta Dube et al., *Cumulative Childhood Stress and Autoimmune Diseases in Adults*, 71 PSYCHOSOMATIC MED. 243, 246–49 (2009).

44. See Robert F. Anda et al., *Adverse Childhood Experiences and Chronic Obstructive Pulmonary Disease in Adults*, 34 AM. J. PREVENTIVE MED. 396, 401–02 (2008).

45. See Maxia Dong et al., *Adverse Childhood Experiences and Self-Reported Liver Disease: New Insights into the Causal Pathway*, 163 ARCHIVES INTERNAL MED. 1949, 1952–53 (2003).

46. See Chapman, *supra* note 18.

47. See Whitfield, *supra* note 18.

48. See Dube, *supra* note 18.

49. See, e.g., Flaherty, *supra* note 20, at 627 tbl.4.

pilot testing for an ACE screening tool, researchers demonstrated links between risk exposure and childhood-onset health and behavioral problems.⁵⁰ They collected data on 102 children between the ages of four and five years who received check-ups over a six month period at a doctor's office serving a low-income community.⁵¹ Their mothers or other female primary caretakers were asked to report on seven child ACE measures, as well as maternal marital status,⁵² maternal education,⁵³ and child health status.⁵⁴ Physician investigators verified child health status through medical chart reviews.⁵⁵ Ninety-four percent of the parents or adult caregivers reported that their child experienced at least one ACE.⁵⁶ Recent research found that forty-seven percent of the children studied had experienced three or more ACEs, and were considered at higher risk for poor health outcomes including behavioral problems, developmental delay, and acute injuries.⁵⁷ Other studies have found high ACE scores to be associated with fair or poor general health,⁵⁸ illness requiring a doctor,⁵⁹ and obesity among children.⁶⁰ By age thirteen, Selena's health already demonstrates these correlations; she is struggling with substance abuse and depression, and is at risk for obesity.

B. Understanding the Link Between Childhood Trauma and Poor Mental and Physical Health

The impact of trauma on the brain helps to explain the connection between the adverse experiences of a child like Selena and her increased risk for health risk behaviors and poor health conditions. Although the mechanisms underlying the

50. See Ariane Marie-Mitchell & Thomas G. O'Connor, *Adverse Childhood Experiences: Translating Knowledge into Identification of Children at Risk for Poor Outcomes*, 13 ACAD. PEDIATRICS 14, 16–18 (2013).

51. *Id.* at 15.

52. *Id.* Maternal marital status was ascertained by self-report.

53. *Id.* No maternal high school degree or GED was considered a positive risk factor.

54. *Id.*

55. *Id.*

56. *Id.* at 16 tbl.1. The most prevalent ACE measures were single parent household (76%), low maternal education (57%), and household mental illness (41%). *Id.* at 16.

57. *Id.* at 16. Researchers often use four or more ACEs as a cut-off point for determining increased risk. Because the ACE screen in this study was less comprehensive, in that it only included one category for child maltreatment – and used a higher risk population, the authors used a cut-off score of three or more for the dichotomization between high risk and low risk. Thus, those 47% were considered to be at higher risk for experiencing for poor health outcomes. The percent of children who already expressed poor outcomes and had ACE scores greater than or equal to three was determined outcome by outcome. Moreover, contrary to expectations and previous research, accumulated risk was also associated with lower body mass index (BMI), decreased likelihood of medically reported asthma, and decreased healthcare utilization. *Id.* at 17 tbl.3.

58. Flaherty, *supra* note 20, at 627 tbl.4.

59. *Id.*

60. Burke, *supra* note 20, at 411.

biological embedding of childhood trauma are still being explored,⁶¹ the correlation between traumatic experiences and increased risk of poor physical and mental health outcomes can be explained by the impact of toxic stress.⁶² In the absence of buffering protection afforded by support from caring adults, high exposure to childhood adversity and trauma can result in strong, prolonged, or frequent activation of the body's stress response system, known as "toxic stress."⁶³ When a child starts daycare or gets a vaccine, or experiences other forms of "positive" stress, "the proverbial 'fight-or-flight response' may kick in temporarily."⁶⁴ However, when that stress response is prolonged and not mitigated by the stable support of a parent or other caregiver, it can become toxic, and lead to a chronically heightened stress response system, resulting in actual changes to the brain.⁶⁵ Persistent toxic stress can disrupt brain circuitry and other organ and metabolic systems in ways that influence not only behavior but also physiology, in the short-term and decades later.⁶⁶ In fact, chronic toxic stress can permanently

61. Biological embedding is defined as "the process whereby differential human experiences systematically affect the healthfulness of life across the life cycle." Clyde Hertzman, *The Biological Embedding of Early Experience and its Effects on Health in Adulthood*, 896 ANNALS N.Y. ACAD. SCI. 85, 89 (1999).

62. Toxic stress is defined as the strong, prolonged, or frequent activation of the body's stress response systems in the absence of the buffering protection afforded by support from caring adults. Nat'l Sci. Council on the Developing Child, *Excessive Stress Disrupts the Architecture of the Developing Brain* 1 (Harvard Univ. Ctr. on the Developing Child, Working Paper No. 3, 2014), http://developingchild.harvard.edu/wp-content/uploads/2005/05/Stress_Disrupts_Architecture_Developing_Brain-1.pdf [<https://perma.cc/4W7B-VS29>] [hereinafter Working Paper No. 3].

63. Shonkoff et al., *supra* note 4, at e236.

64. Jennifer S. Middlebrooks & Natalie C. Audage, *The Effects of Childhood Stress on Health Across the Lifespan*, CTR. DISEASE CONTROL & PREVENTION 3 (2008), https://www.bisccmi.org/revisitingtraumatology/childhood_stress.pdf [<https://perma.cc/B3YV-V88S>].

65. Shonkoff et al., *supra* note 4, at e236; see also Middlebrooks & Audage, *supra* note 65.

66. *Id.* Several mechanisms have been proposed in order to explain the biological processes by which toxic stress effects development. One of the most frequency cited mechanisms involves prolonged elevation of cortisol levels. In the face of stressors, the immune system produces proinflammatory cytokines. These cytokines in turn activates the hypothalamic-pituitary adrenal axis (HPA), which under normal conditions produces cortisol to extinguish the HPA and inflammatory response. Sarah B. Johnson et al., *The Science of Early Life Toxic Stress for Pediatric Practice and Advocacy*, 131 PEDIATRICS 319, 321 (2013). Toxic stress impedes this regulatory process and increases cortisol production. *Id.* at 321–22. Long-term effects of elevated cortisol levels include sensitized proinflammatory pathways, suppressed immune function, alterations in the architecture of brain regions responsible for learning, memory, and emotion, and contributions to metabolic syndrome, bone mineral loss, and atrophy. Working Paper No. 3, *supra* note 62, at 3. Other proposed direct effects of toxic stress include increased leukocyte telomere degradation and epigenetic activated and deactivation of specific genes. Ehrlich, *supra* note 16, at 25, 27. Childhood emotional and physical abuse has been associated with shorter telomeres in which blood cells. Telomeres are non-coding segments of DNA that act like caps to prevent DNA degradation when cells divide. When telomeres degrade, cells enter a phase known as senescence where replication ceases and functional capacity is limited. As a result, risks for morbidity and mortality from various conditions increase.

66. In addition, stress due to childhood adversity has been shown to turn some genes "on" and

affect the expression of genes involved in stress response regulation, brain development and functioning, and immune function.⁶⁷

Toxic stress can also lead to unhealthy lifestyles through risky behaviors, such as Selena's frequent marijuana use and eating to make herself feel better, which people adopt as coping mechanisms.⁶⁸ Higher ACE exposure has been linked to higher rates of risk-taking behaviors such as tobacco use, illicit drug abuse, obesity, promiscuity, and pathologic gambling.⁶⁹ These behaviors are estimated to contribute to as many as forty percent of early deaths.⁷⁰

Children exposed to trauma can experience a panoply of mental health challenges; they are more likely to exhibit negative affect, respond inappropriately to situations, have problematic social interactions with peers, and demonstrate ambivalence to their parents or other caregivers.⁷¹ The frequent sadness that Selena feels is understandable. Over time, these reactions can evolve into psychiatric disorders, such as posttraumatic stress disorder (PTSD), separation anxiety, and depression.⁷² As adults, children with histories of trauma and abuse are more likely to develop depression, anxiety, antisocial personality disorder, and borderline personality disorder, to attempt suicide, and to have challenges with substance abuse.⁷³ Although formal diagnoses of mental illness are most often associated with adult patients, many children who experience trauma actually begin to develop these conditions earlier in life and they often persist into adulthood.⁷⁴

With fewer than 20 percent of youth with a diagnosable mental disorder receiving an evaluation or treatment services,⁷⁵ the toll of these conditions on our

others "off" at particular times in locations. *Id.* at 25.

67. Ross A. Thompson, *Stress and Child Development*, 24 FUTURE OF CHILDREN 41, 48 (2014). The study cited compared epigenetic changes in a group of children raised in orphanages with a group raised by their biological parents.

68. See Shonkoff et al., *supra* note 4, at e237.

69. *Id.* at e237.

70. *Id.* at e238.

71. Ann T. Chu & Alicia F. Lieberman, *Clinical Implications of Traumatic Stress from Birth to Age Five*, 6 ANN. REV. CLINICAL PSYCHOL. 469, 478 (2010).

72. *The 12 Core Concepts: Concepts for Understanding Traumatic Stress Responses in Children and Families*, NAT'L CHILD TRAUMATIC STRESS NETWORK (2012), <http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts/12-core-concepts> [<https://perma.cc/D9KQ-3RH4>].

73. Daniel P. Chapman et al., *Adverse Childhood Events as Risk Factors for Negative Mental Health Outcomes*, 37 PSYCHIATRIC ANNALS. 359 (2007).

74. According to the National Comorbidity Survey Replication study, half of all diagnosable mental illnesses began by age fourteen and seventy-five percent by age twenty-four. Vikram Patel et al., *Mental Health of Young People: A Global Public-Health Challenge*, 369 LANCET 1302, 1306 (2007). Moreover, most disorders likely to persist into adulthood had ages of onset during the 12–24 year age range. *Id.*

75. See, e.g., Joshua Breslau, et al., *Mental Disorders and Subsequent Educational Attainment in a U.S. National Sample*, 42 J. PSYCHIATRIC RES. 708, 708–716 (2008); Sheryl H. Kataoka, *Unmet Need of Mental Health Care Among U.S. Children: Variation By Ethnicity and Insurance Status*, 159 AM. J. PSYCHIATRY 1548, 1548–1555 (2002); Vander Stoep, et al., *What Proportion of Failure to*

youth is grave. Mental illness is the cause of more hospitalizations among teens than any other condition,⁷⁶ and suicide is the second leading cause of death in youth ages ten to twenty-four.⁷⁷ And the financial costs can be staggering; the Institute of Medicine in 2009 estimated the annual cost of early onset mental health disorders at more than \$247 billion per year.⁷⁸

Once children begin experiencing poor mental health, they are at higher risk for many other health and developmental issues such as poor educational achievement, substance use and abuse, violence, and challenges with reproductive and sexual health.⁷⁹ The research similarly shows that mental illness in adolescence can also harm educational achievement⁸⁰ and later socio-economic status.⁸¹ The spiraling effect of unaddressed children's mental health issues strains many systems, such as the educational, child welfare, and juvenile justice systems.⁸² Selena's school avoidance and marijuana use could lead her to face school suspension or other consequences, such as involvement in the juvenile delinquency system. As the juvenile justice, child welfare, and crisis-oriented mental health services systems are highly resource intensive, the financial implications are also significant.

C. Reducing the Impact of Childhood Trauma: The Need for Early Identification and Intervention

Selena's path could have improved greatly if she had been connected early on to needed mental health services to address her trauma. Early identification and interventions to address ACEs and toxic stress can help to mitigate their harmful impact so that children are given a chance to achieve more optimal mental and

Complete Secondary School in the U.S. Population is Attributable to Adolescent Psychiatric Disorder?, 30 J. BEHAV. HEALTH SERVS. & RES. 119, 119–24 (2003).

76. Pamela L. Owens, et al., *Care of Children and Adolescents in U.S. Hospitals*, AGENCY HEALTHCARE RES. & QUALITY (Oct. 2003), <https://archive.ahrq.gov/data/hcup/factbk4/factbk4.pdf> [<https://perma.cc/J8WN-2LZK>].

77. *WISQARS™ Leading Cause of Death Reports*, CTRS. DISEASE CONTROL & PREVENTION, <https://webappa.cdc.gov/sasweb/ncipc/leadcause.html>.

78. *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities*, NAT'L RES. COUNCIL & INST. MED. (Mary Ellen O'Connell et al., eds. 2009), https://download.nap.edu/cart/download.cgi?record_id=12480 [<https://perma.cc/6JAV-FRN9>] [hereinafter *Preventing MEB Disorders*].

79. See Patel, *supra* note 74, at 1302.

80. Ronald C. Kessler et al., *Social Consequences of Psychiatric Disorders, I: Educational Attainment*, 152 AM. J. PSYCHIATRY 1026, 1026–1032 (1995).

81. Ronald C. Kessler et al., *Individual and Societal Effects of Mental Disorders on Earnings in the United*

States: Results from the National Comorbidity Survey Replication, 165 AM. J. PSYCHIATRY 703, 703–711 (2008).

82. *Preventing MEB Disorders*, *supra* note 78, at 15–16.

physical health over the course of their lifetime.⁸³ The first several years of life and adolescence are especially critical years during which psychosocial factors have a disproportionately large impact on development.⁸⁴ Even at age thirteen, treatment to help her cope with the trauma she experienced as a child and to improve her mental health could have helped her long-term trajectory. But without access to necessary mental health treatment over time, a child's mental health status suffers as a result of trauma, as do his or her overall health outcomes.⁸⁵ If prevention and treatment intervention can be effectively implemented during early childhood, children will develop more appropriate stress responses and face lower risk of mental health challenges.⁸⁶ Later interventions are more likely to require greater intensity and cost in order to overcome well-established neural networks in the brain and routinized behavioral patterns.⁸⁷ If they are deployed early, interventions have the greatest impact—and also yield lower costs in such wide ranging areas as remedial education, clinical treatment, public assistance and incarceration.⁸⁸ If children in need of mental health services can access treatment early in life, the costs to them and to society can be reduced.⁸⁹

The pathway to this early intervention begins with identification of the need.

83. See, e.g., Michael Regalado & Neal Halfon, *Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years: Review of the Literature*, 155 ARCHIVES PEDIATRIC & ADOLESCENT MED. 1311 (2001).

84. Sharon E. Fox et al., *How the Timing and Quality of Early Experiences Influence the Development of Brain Architecture*, 81 CHILD DEV. 28 (2010); Jack P. Shonkoff, *Leveraging the Biology of Adversity to Address the Roots of Disparities in Health and Development*, 109 PROC. NAT'L ACAD. SCI. 17302, 17304 (2012).

85. In children ages 5–14, mental illnesses cause 15 percent of the disability-adjusted life years (DALYs) lost to illness. In youths age 15–24 this number doubles; during this period, almost two-thirds of DALYs lost are due to causes strongly associated with mental illness and substance abuse. “One DALY can be thought of as one lost year of “healthy” life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.” *Metrics: Disability-Adjusted Life Year (DALY)*, WORLD HEALTH ORG., http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en [https://perma.cc/X62P-236J]; *Preventing MEB Disorders*, *supra* note 78, at 17.

86. Hillary A. Franke, *Toxic Stress: Effects, Prevention, and Treatment*, 1 CHILDREN 390, 394 (2014).

87. Thompson, *supra* note 67, at 51.

88. Suggested economic effects of early rather than late intervention include lower costs in remedial education, clinical treatment, public assistance, and incarceration. Jack P. Shonkoff & Pat Levitt, *Neuroscience and the Future of Early Childhood Policy: Moving from Why to What and How*, 67 NEURON 689, 691 (2010). In a study conducted by Shirtcliff and colleagues, children brought up in orphanages but subsequently adopted into stable homes showed similar inability to keep the herpes simplex virus dormant as adolescents with recent histories of trauma. Elizabeth Shirtcliff et al., *Early Childhood Stress is Associated with Elevated Antibody Levels to Herpes Simplex Virus Type 1*, 106 PROC. NAT'L ACAD. SCI. 2963 (2009). Even rodent studies have found that offspring born to low nurturing mothers but raised in high nurturing environments develop normal endocrine and behavioral responses. Darlene Francis et al., *Nongenomic Transmission Across Generations of Maternal Behavior and Stress Responses in the Rat*, 286 SCIENCE 1155, 1156 (1997).

89. Patel, *supra* note 74, at 1306.

When children receive mental health screenings that identify trauma and related mental health needs, those children can then be referred for more in-depth psychological and psychiatric evaluations when necessary and to appropriate mental health treatment. Mental health treatment for children can include interventions focused on their families, community-based treatments, and school-based interventions.⁹⁰ These interventions are specifically targeted at children and are most effective when provided early in life.⁹¹ Even babies who have experienced trauma, like Selena, can benefit from infant mental health services, which engage parents and caregivers like Amelia and Aunt Joann, together with the infant, to promote mental health, prevent further trauma, and treat its symptoms.⁹² Infant mental health services could have helped to palliate Selena's mental health problems, and supported her mother and aunt in nurturing her healthy childhood development.⁹³

Beyond infancy, there are a panoply of treatments for traumatized children like Selena and their families that are evidence-based, meaning those services have been shown through scientific research to be effective in improving outcomes.⁹⁴ Many of these treatments engage the child's parent or caregiver, as well as the child, to support that relationship and improve the well-being of the family. For example, treatment aimed at both a parent and child can be especially critical when both have been exposed to trauma. Because Amelia was a victim of interpersonal violence that was also witnessed by her child, treatment could have been instrumental in addressing both of their related needs. Research shows that "traumatized adults may experience post-traumatic stress symptoms such as avoidance and withdrawal, which limit their availability and responsiveness to the child. Simultaneously, exposure to a traumatic event creates in the child stress symptoms that are exacerbated by the indirect effect of the caregiver's compromised responsiveness."⁹⁵ Amelia and Selena could have participated in

90. *Id.* at 1182–83.

91. Kimberly Eaton Hoagwood et al., *Evidence-Based Practice in Child and Adolescent Mental Health Services*, 52 *PSYCHIATRIC SERVS.* 1179, 1181 (2001).

92. *Infant-Early Childhood Mental Health*, ZERO TO THREE (Feb. 10, 2016), <https://www.zerotothree.org/resources/110-infant-early-childhood-mental-health> [https://perma.cc/6QZG-SDBP]; see also *Infant Mental Health Journal*, WORLD ASS'N INFANT MENTAL HEALTH, <http://www.waimh.org/i4a/pages/index.cfm?pageid=3292> [https://perma.cc/X6EA-8WYJ].

93. ZERO TO THREE, *supra* note 92.

94. The American Psychological Association describes evidence-based practice in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences," with the best available research referring to "scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields." *Policy Statement on Evidence-Based Practice in Psychology*, AM. PSYCHOL. ASS'N (Aug. 2005), <http://www.apa.org/practice/guidelines/evidence-based-statement.aspx> [https://perma.cc/GP7E-HV2P].

95. Ann T. Chu & Alicia F. Lieberman, *Clinical Implications of Traumatic Stress from Birth to*

child-parent psychotherapy, which has been shown to reduce a child's behavioral problems as well as mental health symptoms associated with trauma for both child and parent.⁹⁶ Play therapy could have helped to lower Selena's toxic stress response.⁹⁷

As Selena came into the care of her Aunt Joann, evidence-based treatments would have engaged Joann in Selena's therapy, even though Joann herself may not have experienced trauma like Amelia. Because a child's traumatic stress responses are linked with the quality of the child-caregiver relationship, treatments like functional family therapy seek to build bonds between a traumatized child like Selena and her caregiver, Aunt Joann.⁹⁸ Regular home visits by a trained community health worker may have helped her to become less anxious, display fewer symptoms of depression, and have fewer disciplinary issues at school during adolescence.⁹⁹ As Selena began to struggle in school and turn to marijuana use, Selena and Joann could perhaps have benefited from behavioral management help from a social worker, known as multisystemic therapy.¹⁰⁰ School-based interventions can also have powerful results.¹⁰¹

Age Five, 6 ANN. REV. CLINICAL PSYCHOL. 469, 478 (2010).

96. Child-parent psychotherapy improves the relationship between a child and her parents by reinforcing the child's perception of the parent as a competent and reliable protector and helping parents understand the meaning of a child's behavior. This type of psychotherapy is not only significantly effective in reducing children's behavioral problems and symptoms of post-traumatic stress disorder, but also can improve a mothers' symptoms of avoidance of trauma triggers, helping traumatized mothers be more responsive to their children. A 6-month follow-up found that these improvements were sustained. *Id.*

97. "Play therapy allows children to express themselves through play and activity. This theory assumes that "children will use play materials to directly or symbolically act out feelings, thoughts, and experiences that they are not able to meaningfully express through words." Sue C. Bratton et al., *The Efficacy of Play Therapy with Children: A Meta-Analytic Review of Treatment Outcomes*, 36 PROF. PSYCHOL.: RES. & PRAC. 376, 376 (2005). Combinations of play therapy and training and support for caregivers have been shown to lower the toxic stress response of children who have experienced maltreatment. Thompson, *supra* note 67, at 51.

98. Functional family therapy involves a three-stage engagement process of (1) building a therapeutic bond with family, (2) enabling adept family problem-solving, and (3) helping families generalize problem-solving skills to new scenarios.⁹⁸ Functional family therapy has long-term positive outcomes; for example, this service reduces recidivism in juvenile offenders with conduct disorders by 26–73%, as compared to routine services. Alan Carr, *The Effectiveness of Family Therapy and Systemic Interventions for Child-Focused Problems*, 31 J. FAM. THERAPY 3, 16 (2009)

99. Regular home visits by a trained community health worker to high risk families have led to promising results, where those babies ultimately become adolescents who are less anxious, display fewer symptoms of depression, and have improved self-esteem, as well as fewer attention problems and fewer disciplinary issues at school. Patel, *supra* note 74, at 1305.

100. Multisystemic therapy deploys a social worker or other highly qualified professional to work with youth and their families to better manage behaviors by helping an adolescent and her family draw on their strengths to develop and implement new skills as part of an action plan to disrupt problematic patterns. Carr, *supra* note 98, at 17. Families who engage in multisystemic therapy have shown "greater improvements in family problems and parent-child interaction" for treatment of physical abuse and neglect. Carr, *supra* note 98, at 17.

101. For example, Resilient Peer Treatment pairs socially withdrawn preschool children,

These and other evidence-based children's mental health treatments can serve as critical tools to disrupt the path from ACEs and other forms of early childhood trauma to poor health and mental health. If children can access these services early in life,¹⁰² they are more likely to experience improved outcomes.¹⁰³ To facilitate access to these services early in life, systems need to be in place to screen children and identify those at high risk.¹⁰⁴ Early intervention necessarily starts with identification, and healthcare providers can play a key role in identification by screening children when they come to the doctor for a check-up.¹⁰⁵

II. FULFILLING THE MEDICAID PROMISE: A ROUTE TO WIDESPREAD EARLY IDENTIFICATION AND INTERVENTION TO IMPROVE THE HEALTH AND MENTAL HEALTH WHO HAVE SUFFERED TRAUMA

"[W]e make this commitment to our youth not merely at the bidding of our conscience. It is practical wisdom. It is good economics. But, most important, as Franklin D. Roosevelt said thirty years ago, because 'the destiny of American youth is the destiny of America.'"¹⁰⁶

Through the enactment of the Medicaid program, "Congress embarked on an ambitious program to provide medical care for the country's poorest people."¹⁰⁷ In 1967, President Lyndon B. Johnson laid the groundwork for legislation to identify and treat the healthcare needs of children living in poverty as early as possible through an expansion of the services required by Medicaid. President Johnson argued that "[o]ur whole society pays a toll for the unhealthy and crippled children who go without medical care: a total of incalculable human suffering, unemployment, rising rates of disabling disease, and expenditures for special education and institutions for the handicapped."¹⁰⁸ In addition to the moral duty to

including those with trauma histories, with a peer in the same classroom who is coached by a play supporter. With numerous play sessions over several months, research shows that this treatment results in the previously withdrawn children engaging more collaboratively in play with their peers. Chu & Lieberman, *supra* note 95, at 486.

102. Barbara J. Burns et al., *Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey*, 43 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 960 (2004) (stressing the importance of identifying mental health problems in children in the child welfare system early, and providing treatment quickly).

103. Carr, *supra* note 98 (noting that functional family therapy reduces recidivism in juvenile offenders with conduct disorders by 26–73%, as compared to routine services).

104. Emalee G. Flaherty & John Stirling, Jr., *The Pediatrician's Role in Child Maltreatment Prevention*, 126 PEDIATRICS 833 (2010). Currently, the American Academy of Pediatrics recommends screening for factors such as social isolation, poverty, low educational achievement, single-parent homes, history of domestic violence, young parental age, and parental mental health issues.

105. *Id.*

106. 13 CONG. REC. 2883, 2885 (Feb. 8, 1967) (statement of President Lyndon B. Johnson).

107. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 24 (D. Mass. 2006).

108. 13 CONG. REC. 2883, 2885 (Feb. 8, 1967) (statement of President Lyndon B. Johnson).

reduce the infant death rate and the number of children suffering from debilitating conditions,¹⁰⁹ policymakers were concerned by findings from Vietnam War draftee health exams¹¹⁰ that one in four young men who were medically disqualified for service would not have been rejected by the Selective Service for orthopedic or hearing defects had they received “timely medical attention.”¹¹¹ Healthier children could become healthier adults better poised to serve in the military and defend our nation. With these economic and practical drivers in mind, President Johnson advocated for policies to ensure the “discover[y], as early as possible, the ills that handicap our children.”¹¹²

A. Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services for Children

The amendments to the Social Security Act consequently passed that year by Congress required states to provide Medicaid-enrolled children periodic screening and “health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.”¹¹³ In further defining and expanding these critical components of children’s Medicaid, now known collectively as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services, Congress recognized that “adherence to clearly effective and cost-effective well-child care could be worth the immediate outlays” and that “the availability of diagnostic and treatment services is critical to [] children’s health status.”¹¹⁴ In promulgating accompanying regulations, the U.S. Department of Health and Human Services

109. *E.g.*, President’s Proposals for Revision in the Social Security System: Hearing on H.R. 5710 Before the H. Comm. on Ways & Means, 90th Cong. 189 (1967) (statement of John Gardner, Sec’y of Health, Educ., & Welfare) (“Too many infants die who would have lived had they received medical attention. Too many children suffer from chronic handicapping conditions that could have been prevent, corrected, or improved by early treatment.”).

110. Sara Rosenbaum et al., *EPSDT at 40: Modernizing a Pediatric Health Policy to Reflect a Changing Health Care System*, CTR. HEALTH CARE STRATEGIES, INC. 3 (July 2008).

111. Social Security System Hearing, *supra* note 109.

112. 13 CONG. REC. 2883, 2885 (Feb. 8, 1967) (statement of President Lyndon B. Johnson).

113. Social Security Amendments of 1967, Pub. L. No. 90-248, §302, 81 Stat. 929 (1968) (amended 1989). The original text read “(B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the secretary.” *Id.*

114. Office of Tech. Assessment, *Healthy Children: Investing in the Future*, U.S. CONGRESS 23 (Feb. 1988), <http://ota.fas.org/reports/8819.pdf> [<https://perma.cc/XAE8-7VUE>]; *see also* SUBCOMM. ON HEALTH & THE ENV’T OF THE HOUSE COMM. ON ENERGY & COMMERCE, REPORT ON MEDICARE AND MEDICAID HEALTH BUDGET RECONCILIATION AMENDMENTS OF 1989, at 65 (Comm. Print 1989) (citing the Office of Technology Assessment’s report and noting potential cost savings from effective screening and care). The Congressional Record for the Deficit Reduction Act of 2005 clarifies the continuing protections afforded by Medicaid EPSDT. 152 CONG. REC. H46 (daily ed. Feb. 1, 2006) (statement of Rep. Slaughter) (noting a “clear legislative intent that all children should continue to receive access to coverage of early and periodic screening, diagnostic, and treatment services”).

(H.H.S.) similarly emphasized EPSDT's purpose to "[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly."¹¹⁵ The EPSDT children's health program is mandatory for the fifty states and territories that have agreed to participate in Medicaid.¹¹⁶ It provides a comprehensive set of medical benefits for Medicaid-eligible children and youth who are under the age of 21.¹¹⁷ The program's core components are those spelled out in its EPSDT title: (1) early and periodic screening, (2) diagnosis, and (3) treatment services.¹¹⁸

B. Early And Periodic Screening for Mental Health Can Disrupt the Trauma Cycle

More than 42 million children now receive their healthcare through the Medicaid program.¹¹⁹ With such widespread reach, Medicaid's early and period screening requirement provides a critical structure for identifying trauma early and providing necessary mental health services. For a child like Selena, her annual check-ups were an opportunity for her doctor to screen her for trauma and mental health needs and refer her for critical treatment that could have provided her with a healthier start in life and healthier outcomes down the road. Indeed, regular screening services are the foundation of EPSDT; children's health problems can only be treated if medical providers are aware of them. When a child covered by Medicaid goes to the doctor throughout childhood and adolescence for check-ups known as a well-child checks, the child should receive holistic screening that includes a mental health assessment at each appointment. Congress directed states to ensure that these doctor's visits go beyond traditional height, weight, and basic physical exams: specifically, Medicaid EPSDT requires that states ensure medical, vision, hearing, and dental screenings are regularly provided to children.¹²⁰ The first component, the medical screening, must include a comprehensive health and developmental history assessing both physical and mental development.¹²¹ A

115. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 5010.B [hereinafter CMS MEDICAID MANUAL].

116. See Social Security Act, 42 U.S.C. §§ 1396a(a)(10)(A) and 1396a(a)(43) (2012).

117. 42 U.S.C. § 1396d(r) (2012). State participation in Medicaid is voluntary, but once a state opts to participate, it must comply with the Act and all regulations promulgated by the federal Centers for Medicare and Medicaid Services (CMS) in order to obtain federal funds. See *Bowen v. Mass.*, 487 U.S. 879, 883 (1988).

118. See 42 U.S.C. § 1396d(r) (2012).

119. See CTRS. FOR MEDICARE & MEDICAID SERVS., *Form CMS-416: Annual EDST Participation Report* (2015). According to the latest available national data, 42,150,534 individuals aged 0–20 were eligible at some point for EPSDT. 39,723,800 were eligible for 90 continuous days. See *Early and Periodic Screening, Diagnostic, and Treatment*, CTRS. MEDICAIR & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html> [<https://perma.cc/H35D-85EN>] (describing Form CMS-416 and linking to data).

120. See 42 U.S.C. § 1396d(r)(1)–(4) (2012).

121. The medical screen must also include a comprehensive unclothed physical examination and

screening constitutes the critical first step towards identification and understanding of a child's challenges and the gateway towards the receipt of the services a child needs to get healthy. If needs are identified during a screening, a child must subsequently be provided any medically necessary healthcare, diagnostic services, treatment and other measures to "to correct or ameliorate" those conditions that were discovered,¹²² such as more comprehensive psychological evaluations and the types of evidence-based children's mental health treatment described above.

While screenings must generally "be provided in accordance with reasonable standards of medical and dental practice,"¹²³ the Medicaid statute and regulations provide little guidance to states and providers as to how to assess a child's mental health in the doctor's office or what a mental health screening should encompass.¹²⁴ Guidance from the Centers for Medicare and Medicaid Services (CMS) explains that assessments should be age-appropriate and examine the social-emotional needs of young children and possible peer relation issues, substance abuse, and psychological conditions in adolescents. However, CMS guidance does not identify specific screening tools that should be used for evaluation. As a result, states and providers are still left without specificity as to which screening tools or protocols are appropriate or effective, and would satisfy Medicaid's mental health screening requirement for children.¹²⁵ There are a wide variety of screening tools that can be used to assess for mental health as part of a broader developmental screening or separately for trauma and mental health needs.¹²⁶

health education. 42 U.S.C. § 1396d(r)(1)(B) (2012); 42 C.F.R. §441.56(b)(1) (2016).

122. *Id.*

123. 42 C.F.R. § 441.56(b)(2) (2016).

124. 42 U.S.C. § 1396d(r)(1)(B) (2012); 42 C.F.R. §441.56(b)(1) (2016).

125. The Manual does not identify specific screening tools that should be used during the evaluation in order "to avoid any connotation that only certain tests or instruments satisfy Federal requirements," and instead directs physicians to use any information acquired to objectively evaluate whether the child is within expected developmental ranges. Although this guidance provides some additional detail, states are largely left without a federal definition of what constitutes an adequate mental health screening. See CMS STATE MEDICAID MANUAL, *supra* note 115, at § 5123.2(1)(a), (b).

126. For general developmental screening, the American Academy of Pediatrics (AAP) recommends a variety of screening tools, including the Ages & Stages Questionnaire (ASQ). The ASQ has been normed on children from diverse socioeconomic and ethnic backgrounds and has moderate to high sensitivity and specificity. Council on Children with Disabilities et al., *Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening*, 118 PEDIATRICS 405, 410–13 (2006). For psychological and behavioral screenings, the AAP recommends the use of the Pediatric Symptom Checklist, Youth Report, or Strengths and Difficulties Questionnaire. *Bright Futures Tool and Resource Kit: Developmental, Behavioral, Psychosocial, Screening, and Assessment Forms*, AM. ACAD. PEDIATRICS, <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx> [<https://perma.cc/LLT2-B6CN>]; see also *Screening and Assessment*, in SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES 91 (2014), https://www.ncbi.nlm.nih.gov/books/NBK207201/pdf/Bookshelf_NBK207201.pdf [<https://perma.cc/2MJV-E22S>]; Jane Ellen Stevens, *To Prevent Childhood Trauma, Pediatricians*

Without effective tracking systems in most states, it is difficult to tell whether children receive the required comprehensive screenings, including mental health screening, when they see the doctor for a well child check.¹²⁷ What information has been reported by states shows that there is a wide variance among states in the frequency required for well child checks and in the screening components that should be administered at different ages.¹²⁸ Alarming, available data shows that

Screen Children and Their Parents. . . And Sometimes, Just Parents. . . For Childhood Trauma, ACES TOO HIGH NEWS (July 29, 2014), <https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parents-and-sometimes-just-parents> [<https://perma.cc/3QYL-BPEW>] (describing the use of ACEs screening tools to identify trauma histories in a pediatric practice).

127. Defendants' 8/29/06 Remedial Plan Proposal at 6, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199).

128. Each state sets its own periodicity schedule for how regularly children should be seen for well-child check screens and what each visit should include, but these schedules typically involve frequent visits every few months in infancy and toddlerhood and then annual or bi-annual visits later in adolescence. *See, e.g.*, 405 IND. ADMIN. CODE 5-15-8 (2016); MD. CODE REGS. 10.09.23.01(B)(4) (2016). The American Academy of Pediatrics' recommends the Bright Futures periodicity schedule, which requires history taking, measurements, sensory screening, developmental/behavioral assessment, physical examination, procedures, oral health assessment, and anticipatory guidance, as well as body mass index (BMI) measurements, depression screenings, alcohol/drug use assessments, and the use of verified screening tools for developmental, behavioral, and psychosocial assessments. The AAP recommends screenings as a newborn; at 3–5 days; at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months; and every year thereafter. *Recommendations for Preventive Pediatric Health Care*, AM. ACAD. OF PEDIATRICS, https://www.aap.org/en-us/Documents/periodicity_schedule.pdf [<https://perma.cc/6K38-UYK3>].

At least twenty-six states have adopted the AAP's Bright Futures recommendations to some extent. *Early & Periodic Screening, Diagnostic, & Treatment Program*, ALASKA DEP'T HEALTH & HUM. SERVS., http://dhss.alaska.gov/dhcs/Pages/epsdt_hcs.aspx [<https://perma.cc/L825-UF4G>]; *Provider Manual*, ARK. MEDICAID § 215.100 (2015), https://www.medicaid.state.ar.us/Download/provider/provdocs/Manuals/epsdt/EPSDT_II.doc [<https://perma.cc/7MTX-NQ2Z>]; *Periodicity Schedules*, CAL. DEP'T HEALTH CARE SERVS. (May 20, 2016 10:09 AM), <http://www.dhcs.ca.gov/services/chdp/Documents/HealthPeriodicity.pdf> [<https://perma.cc/3ACM-MUWB>]; *Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*, COLO. DEP'T HEALTH CARE POL'Y & FINANCING, <https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt> [<https://perma.cc/SUC3-YDD9>]; Div. of Medicaid & Med. Assistance, *Quality Management Strategy*, DEL. HEALTH & SOC. SERV. 33 (2014), http://dhss.delaware.gov/dhss/dmma/files/draft_qms_20140401.pdf [<https://perma.cc/2KLY-LTVL>]; Div. of Medicaid, *Policies & Procedures for Early & Periodic Screening, Diagnostic, & Treatment (EPSDT) Services*, GA. DEP'T OF CMTY. HEALTH at IX-2 (2016), <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/EPSDT%20Health%20Check%20Manual%2020160926134353.pdf> [<https://perma.cc/8YAL-7H3X>]; *Medicaid Provider Manual: Early and Periodic Screening, Diagnosis and Treatment*, MEDQUEST HAWAII 3 (2002), <http://www.med-quest.us/PDFs/Provider%20Manual/PMChp0502.pdf> [<https://perma.cc/4Q2F-9CGD>]; *Idaho MMIS Provider Handbook*, IDAHO MEDICAID 50–56 (July 13, 2017), <https://www.idmedicaid.com/General%20Information/General%20Provider%20and%20Participant%20Information.pdf> [<https://perma.cc/JFW4-NQAE>]; *Handbook for Providers of Healthy Kids Services Chapter HK-200: Policy and Procedures for Health Care for Children*, ILL. DEP'T HEALTHCARE & FAMILY SERVS. 16 (Mar. 2017), <https://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf> [<https://perma.cc/2X2R-FKM2>];

more than a third of Medicaid-enrolled children are not receiving any screenings at all.¹²⁹ When children *are* screened, there is a dearth of data to indicate whether those screenings are comprehensive and specifically whether they include any

Div. of Health Care Fin., *KBH – EPSDT Updates*, KAN. DEP'T HEALTH & ENV'T 8-1 (Apr. 2016), <https://www.knap-state-ks.us/Documents/Content/Bulletins/16058%20-%20General%20-%20KBH-EPSDT.pdf> [<https://perma.cc/2J4Z-ZWRS>]; Cabinet for Health Servs., *EPSDT Screening Services & EPSDT Special Services Policies & Procedures*, KY. DEP'T MEDICAID SERVS. 4.1, <http://www.chfs.ky.gov/NR/rdonlyres/64EFF098-5C67-48B4-8B8B-97EE2E9005BF/0/1034.pdf> [<https://perma.cc/BU6N-NBKK>]; *Pediatric Preventive Health Screenings*, MAINECARE SERV. 2 (Dec. 7, 2016), http://www.maine.gov/dhhs/oms/pdfs_doc/children_IHOC/Pediatric%20Preventive%20Health%20Screenings2017final.pdf [<https://perma.cc/Z65F-3PJ7>]; Clarification of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Covered Services and Definition of “Medically Necessary,” MICHIGAN DEP'T HEALTH & HUMAN SERVS. 1 (Jan. 15, 2016), http://www.michigan.gov/documents/mdhhs/MSA_16-01_510956_7.pdf [<https://perma.cc/3SW4-G4K6>]; *EPSDT Periodic Examination Schedule*, MISS. DIV. MEDICAID (Jul. 2016), <https://medicaid.ms.gov/wp-content/uploads/2016/07/EPSDT-Periodicity-Examination-Schedule.pdf> [<https://perma.cc/Y48J-6F44>]; *General Information for Providers*, MONT. DEP'T HEALTH & HUM. SERVS. 3.2 (Feb. 2017), <http://medicaidprovider.mt.gov/Portals/68/docs/manuals/General/GeneralManual02032017.pdf> [<https://perma.cc/BHC4-8WP3>]; 471 Neb. Admin. Code §33-002.03A (2016); Office of Medicaid Mgmt., *EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid)* N.Y. STATE DEP'T OF HEALTH 9–11 (2005), <https://www.emedny.org/ProviderManuals/EPSDTCTHP/PDFS/EPSDT-CTHP.pdf> [<https://perma.cc/C5SQ-T3XN>]; Div. of Med. Assistance, *N.C. Health Check Program Guide*, N.C. DEP'T HEALTH & HUM. SERVS. 5 (2016), https://ncdma.s3.amazonaws.com/s3fs-public/Health_Check_Program_Guide_2016_10.pdf [<https://perma.cc/ME66-CZSM>]; *General Information for Providers: Medicaid and Other Medical Assistance Programs*, N.D. DEP'T HUM. SERVS. 111 (2012), <http://www.nd.gov/dhs/services/medicalserv/mcicaid/docs/gen-info-providers.pdf> [<https://perma.cc/3LJ4-67J4>]; *EPSDT: Rhode Island Medicaid Early Periodic Screening Diagnosis and Treatment*, R.I. DEP'T HEALTH, https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/RI-Provider-Information/RI_Early_Periodic_Screening_Diagnosis_Treatment.pdf [<https://perma.cc/7Q8P-SNQT>]; *Professional Services Billing Manual*, S.D. MEDICAID 41 (Jul. 2017), <https://dss.sd.gov/formsandpubs/docs/MEDSRVCS/professional.pdf> [<https://perma.cc/2EGQ-XM8N>]; *EPSDT Fact Sheet*, TENN. DEP'T HEALTH, <https://www.tn.gov/health/article/epsdt-fact-sheet> [<https://perma.cc/7M6T-2RM4>]; Bright Futures, *Utah*, AM. ACAD. PEDIATRICS, <https://brightfutures.aap.org/states-and-communities/Pages/Utah.aspx> [<https://perma.cc/PW5P-6379>]; *Health Care and Screening Guidelines*, VT. DEP'T HEALTH (Jan. 3, 2017), <http://healthvermont.gov/children-youth-families/health-care-children-youth/health-care-and-screening-guidelines> [<https://perma.cc/A2UP-WQRP>]; *Virginia EPSDT Periodicity Chart*, Va. DEP'T MED. ASSISTANCE SERVS., http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_poi2.pdf [<https://perma.cc/6NQZ-CQQE>]; *West Virginia EPSDT/HealthCheck Program Periodicity Schedule*, W. VA. DEP'T OF HEALTH & HUMAN SERVS., <http://www.dhhr.wv.gov/HealthCheck/providerinfo/Documents/HC%20periodicity%20schedule%2002-15.pdf> [<https://perma.cc/C9AU-W8AU>].

129. In FY 2015, 33,788,843 children were eligible for at least one initial or periodic screen; only 19,732,638 (58.4%) received one. *Annual EPSDT Participation Report: Fiscal Year 2015*, CTRS. MEDICARE & MEDICAID SERVS. (Sept. 29, 2016), <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2015-epsdt-data.zip> [<https://perma.cc/L8GZ-CLHV>] [hereinafter *EPSDT 2015 Participation Report*]; see Rosie D. v. Romney, 410 F. Supp. 2d at 30-35 (“Without a clinically appropriate, detailed assessment . . . proper treatment is obviously impossible.”).

mental health screening.¹³⁰ A study by the HHS Office of Inspector General of a small sample of medical records across nine states found that 76 percent of children did not receive all required medical, vision, and hearing screenings and nearly 60 percent of children who did receive a medical screening were missing at least one component.¹³¹ In 2001, a survey of state Medicaid programs revealed that 23 states failed to include a single question related to mental health in their EPSDT tools for primary care providers.¹³² A national survey of parents from 2011-2012 found that only 31.5 percent of publicly insured children across the country received a standardized developmental and behavioral health screening between the ages of 10 months and 5 years.¹³³ And a review in 1998 of Minnesota's Medicaid EPSDT system found that only 27 percent of children there received a mental health or developmental screening.¹³⁴ The available data shows that "many children with mental health disorders are never screened, diagnosed, or offered the treatment services to which they are entitled under the Medicaid EPSDT benefit."¹³⁵

130. Najeia Mention & Felicia Heider, *The Nuts and Bolts of Medicaid Reimbursement for Developmental Screening: Insights from Georgia, Minnesota, and North Carolina*, NAT'L ACAD. STATE HEALTH POL'Y 2 (Sept. 2016), <http://www.nashp.org/wp-content/uploads/2016/09/Screening-Brief-Updated.pdf> [<https://perma.cc/ZE8R-CQL9>]. As key exceptions, Massachusetts publishes quarterly reports on behavioral health screenings and North Carolina has published yearly screening rates for all Medicaid-enrolled children 0-5 years old. *Behavioral Health (BH) Screening Cumulative Quarterly Report*, MASS. EXECUTIVE OFFICE HEALTH & HUMAN SERVS., <http://www.mass.gov/eohhs/docs/masshealth/cbhi/reports/bh-screening.pdf> [<https://perma.cc/XUT7-TRF4>] [hereinafter Mass. Screening Reports]; Marian Earls & Kimmy Vuong, *Assuring Better Child Health and Development (ABCD) Program Improves Screening Rates*, COMMUNITY CARE N.C. (2016), <https://www.communitycarenc.org/media/files/data-brief-7-abcd-program-improves-screening-rates.pdf> [<https://perma.cc/4G54-LFYP>]. Because screenings are reported as a single unit rather than by component, however, this data provides no information regarding the comprehensiveness and quality of the screenings conducted. See 42 U.S.C. §1396a(a)(43)(D) (2012) (requiring states to report to the Secretary "the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year: (i) the number of children provided health screening services, (ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services, (iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 1397hh(e) of this title and (iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title").

131. U.S. Dep't of Health & Human Serv., Office of the Inspector Gen., OEI-5-08-00520, *Most Medicaid Children in Nine States are Not Receiving All Required Preventive Screening Services* (2010) [hereinafter OEI-5-08-00520] (finding that in nine states, three of four children did not receive all covered health screening services and nearly sixty percent of those who received EPSDT medical screenings lacked at least one component of a complete screening); U.S. Dep't of Health & Human Serv., Office of the Inspector Gen., OEI-05-13-00690, *CMS Needs to Do More to Improve Medicaid Children's utilization of Preventive Screening Services* (2014).

132. Rafael M. Semansky et al., *Behavioral Health Screening Policies in Medicaid Programs Nationwide*, 54 PSYCHIATRIC SERVS. 736 (2003).

133. *Well-Being of Children*, *supra* note 9, at 22.

134. FMAS Corp., *1999 External Quality Review Study Child and Teen Checkups Participation Rate Review Final Report*, MINN. DEP'T HUM. SERVS. 5 (Aug. 2000).

135. Rosie D. and *Mental Health Screening: A Case Study in Providing Mental Health Screening*

While children like Selena struggle to cope with the trauma they have experienced, available data suggests that mental health screenings that could identify their mental health needs and facilitate necessary services are not reaching many children. In examining the failure of Massachusetts' Medicaid system to provide children with both mental health screening in the pediatric setting and more intensive mental health evaluations, a federal judge noted "The simplest way to escape the challenge of serving [a seriously emotionally disturbed] child is to avoid conducting the sort of in-depth comprehensive assessment that will reveal the extent of the child's medical needs."¹³⁶ More research is needed to understand how often well-child checks are in fact provided and how frequently the checks that do happen are comprehensive, including the mental health screening and all other required components. The federal government should both require and support states in collecting and analyzing this data and providing it to the U.S. Department of Health and Human Services for further analysis.

While there has been no comprehensive national study of the reasons behind the failure of states to ensure that Medicaid-eligible children receive mental health screenings as part of their well child checks, there are a number of possible contributing factors. Primary care providers already struggle with low reimbursement rates for Medicaid EPSDT well child visits¹³⁷ and feel they have insufficient time to complete all required screening components,¹³⁸ especially

at the Medicaid EPSDT Visit, TEENSCREEN: NAT'L CTR. MENTAL HEALTH CHECKUPS COLUM. U. 1 (2010), <http://www.mass.gov/eohhs/docs/masshealth/cbhi/reports/rosie-d-white-mhscreening.pdf> [https://perma.cc/3VGZ-SWEJ] [hereinafter TEENSCREEN].

136. Rosie D. v. Romney, 410 F. Supp. 2d 18, 35 (2016).

137. Diane L. Frankenfield et al., *Adolescent Patients- Healthy or Hurting? Missed Opportunities to Screen for Suicide Risk in the Primary Care Setting*, 154 ARCHIVES OF PEDIATRICS AND ADOLESCENT MEDICINE 162, 165 (2000) (reporting that most surveyed physicians indicated concerns about inadequate reimbursement for screening for mental health problems as a barrier to screening for suicidality or associated risk factors); Sarah McCue Horwitz et al., *Barriers to the Identification and Management of Psychosocial Issues in Children and Maternal Depression*, 119 PEDIATRICS e208, e212 tbl.3 (2007) (reporting on perceived barriers to providing pediatric mental health services and finding that 50.6% of physicians surveyed agreed that inadequate reimbursement was a barrier to care); Judith A. Savageau et al., *Behavioral Health Screening Among Massachusetts Children Receiving Medicaid*, 178 J. PEDIATRICS 261, 265 (2016).

138. Paul Chung et al., *Preventive Care for Children in the United States: Quality and Barriers*, 27 ANN. REV. PUB. HEALTH 491, 507 (2006) (noting that a lack of time on the part of healthcare providers as to what can be accomplished in a well-child check may be more a matter of perception, as studies show that well child visits that incorporate counseling of patients lasted only two minutes longer than visits where no counseling was provided); Horwitz et al., *supra* note 137, at e212 tbl.3 (finding that 77% of physicians surveyed agreed that lack of time to treat child/adolescent mental health problems was a barrier to care); Melissa D. Klein et al., *Can a Video Curriculum on the Social Determinants of Health Affect Residents' Practice and Families' Perception of Care?*, 14 ACAD. PEDIATRICS 159, 163 (2014); Lewis Margolis & Samuel Meisels, *Barriers to the Effectiveness of EPSDT for Children with Moderate and Severe Developmental Disabilities*, 57 AM. J. ORTHOPSYCHIATRY 424, 427 (1987) (emphasizing insufficient time due to 'inflexibility inherent in the structured session'); Savageau et al., *supra* note 137, at 165.

given the many valuable and competing priorities in a pediatric well child visit.¹³⁹ Some primary care providers have reported concerns about the unavailability of validated mental health screening tools,¹⁴⁰ and the need for training on how to effectively use available tools to identify child and adolescent mental health problems.¹⁴¹ In many communities, primary care physicians are concerned about their own lack of knowledge of available mental health resources for patients with identified problems,¹⁴² shortages of competent and qualified mental health providers to whom they can refer children for follow-up evaluations and services when needs are identified, and long waiting periods for children to see mental health providers.¹⁴³ Physicians have expressed both discomfort and a lack of confidence in providing children mental health screening in primary care visits,¹⁴⁴ and particular concerns about a lack of privacy during adolescent visits,¹⁴⁵ which can be critical to discerning mental health needs.

Moreover, many Medicaid-eligible families lack awareness about EPSDT, the screening requirements, and their rights under the law.¹⁴⁶ Logistical barriers such as lack of access to transportation and inconvenient physician office hours and locations¹⁴⁷ may keep some families from bringing their children in for Medicaid well-child visits. Cultural and family barriers can also play a role, where, for example, some parents do not think well-child visits to a primary doctor for regular screenings are necessary and instead visit their child's doctor only for acute care.¹⁴⁸

More research is needed to understand the barriers experienced by both families and physicians that result in a system where comprehensive screening in well child checks, including mental health screening, is likely not the norm, despite

139. TEENSCREEN, *supra* 135, at 9.

140. Savageau et al., *supra* note 137, at 265.

141. *Id.* at 265; Horwitz et al., *supra* note 137, at e212 tbl.3 (finding that 65% of physicians agreed that lack of training in treatment of children's mental health was a barrier to care and 47.1% agreed that lack of training in identifying children's mental health problems was a barrier to care); Defendants' 8/29/06 Remedial Plan Proposal at 4, 6, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199); TEENSCREEN, *supra* note 135, at 8.

142. Klein et al., *supra* note 138, at 163.

143. Horwitz et al., *supra* note 137, at e212 tbl.3 (finding that 61% of physicians surveyed agreed that lack of competent or qualified mental health providers to which they could refer children/adolescents was a barrier to care); Savageau et al., *supra* note 137, at 265; TEENSCREEN, *supra* note 135.

144. Chung et al., *supra* note 138, at 506 (describing challenges with providers' perceptions of the importance of screening and the perceived inability to provide the necessary services); Klein et al., *supra* note 138, at 163; Margolis & Meisels, *supra* note 138 (emphasizing lack of confidence in the effectiveness of procedures used in Medicaid EPSDT well child checks to actually identify health problems); Savageau et al., *supra* note 137, at 265.

145. Chung et al., *supra* note 138, at 505.

146. Defendants' 8/29/06 Remedial Plan Proposal at 3, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199), at 3 (last visited Jan. 31, 2017); Margolis & Meisels, *supra* note 138, at 427.

147. OEI-5-08-00520, *supra* note 131, at 18; Margolis & Meisels, *supra* note 138, at 427.

148. OEI-5-08-00520, *supra* note 131, at 18.

Medicaid EPSDT's statutory requirement.

III. MULTI-LEVEL RESPONSES BY PHYSICIANS AND ATTORNEYS TO IMPROVE IDENTIFICATION AND EARLY INTERVENTION OF CHILDHOOD TRAUMA AND MENTAL HEALTH NEEDS: LESSONS FROM THE MEDICAL-LEGAL PARTNERSHIP MOVEMENT

Less than twenty percent of a person's health status is actually driven by their clinical care.¹⁴⁹ In fact, over fifty percent is attributable to social determinants of health,¹⁵⁰ non-biological factors related to where people work, learn, live, eat, and play. For example, poverty, education, lack of access to employment, housing conditions, and exposure to family and community violence have a strong influence on a person's health and mortality.¹⁵¹ These issues can manifest as unmet legal needs, which can be addressed through legal assistance by an attorney. A Legal Services Corporation study of nine states found that low-income individuals experienced on average 2-3 legal issues in the prior year.¹⁵² With multiple legal challenging faced by people living in poverty, "the addition of lawyers to the medical team can promote health and address barriers to effective health care. These non-medical needs have legal solutions that, if addressed, can diminish health disparities."¹⁵³ For example, lawyers can advocate for improved housing conditions, safety protections for victims of domestic violence, public benefits that can help put food on the table, educational or employment accommodations for people with disabilities, or access to necessary treatment and evaluations guaranteed by Medicaid law. Through advocacy around these types of civil legal needs, MLPs integrate attorneys onto the healthcare team as an effective strategy for addressing social determinants of health.¹⁵⁴

Health and legal professionals serving people living in poverty are increasingly collaborating through the growing medical-legal partnership movement. In 2015, MLPs provided legal assistance to more than 75,000 patients

149. *Our Approach*, COUNTY HEALTH RANKINGS & ROADMAPS, <http://www.countyhealthrankings.org/our-approach> [https://perma.cc/38QA-ASQS] (summarizing research on relative contribution to health and health outcomes).

150. *Id.*

151. Edward Paul et al., *Medical-Legal Partnerships: Addressing Competency Needs Through Lawyers*, 1 J. GRADUATE MED. EDUC. 304, 304 (2009); *Using Health Center Needs Assessments to Understand and Meet Patients' Health-Harming Civil Legal Needs*, NAT'L CENTER MED.-LEGAL PARTNERSHIP (2016), <http://medical-legalpartnership.org/wp-content/uploads/2016/07/Needs-Assessment-MLP-Fact-Sheet-FINAL.pdf> [https://perma.cc/B2BA-BD33]; COUNTY HEALTH RANKINGS, *supra* note 149.

152. *Documenting the Justice Gap in America*, LEGAL SERVS. CORP. 11 (2007), <http://www.lsc.gov/sites/default/files/LSC/images/justicegap.pdf> [https://perma.cc/6FEY-LMJJ].

153. Ellen Cohen et al., *Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities*, 25 J. GEN. INTERNAL MED. 136, 136 (2010).

154. Tobin Tyler, *supra* note 14, at 234.

to resolve issues that were impeding their health¹⁵⁵ and there are now 155 hospitals and 139 health centers across the nation with attorney partners.¹⁵⁶ These collaborations can provide a platform for early and preventive identification through “an integrated approach to health and legal services that facilitates critical, efficient, shared problem solving among health and legal teams who care for patients with complex health and legal needs.”¹⁵⁷ They also provide a platform for change among health and legal institutions, which can benefit from a more holistic, inter-disciplinary approach to all individuals, and to marginalized and vulnerable children and families in particular. Medical-legal partnerships employ a multi-level response to the complex needs of patients living in poverty that can similarly be deployed to ensure that the mental health needs of children who have suffered trauma are identified and addressed early. This multi-level response has three core components, which build upon each other to present a paradigm for individual, systems, and population level change: (1) collaborative advocacy to improve patient health, (2) transformation of health and legal institutions, and (3) policy change.¹⁵⁸

A. Collaborative Advocacy to Improve Patient Health: Identifying and Serving Children and Families with Mental Health Needs

“Because the explicit integration of social and health care services is central to their mission and vision, health centers serve as an excellent entry point to civil legal aid services for low-income populations Many of these patients have “health- harming civil legal needs,” meaning that at least some of the social, financial, environmental or other problems in their lives have a deleterious impact on their health and are in fact amenable to civil legal solutions. Indeed, one study estimated that between 50 and 85 percent of health center users experience such unmet health-harming civil legal needs.”¹⁵⁹

Through medical-legal partnerships, physicians have come to realize that healthcare delivery often necessitates legal care if disadvantaged patients are to

155. The MLP Response, *supra* note 14.

156. *Partnerships Across the U.S.*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/partnerships> [https://perma.cc/GJ4L-R6HL].

157. Ellen Lawton et al., *Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations*, in

POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL-LEGAL PARTNERSHIP 71, 72 (Elizabeth Tobin Tyler et al. eds., 2011).

158. Tobin Tyler, *supra* note 14, at 234–238 (describing the 3 core components of the MLP response).

159. Marsha Regenstien et al., *Medical-Legal Partnership and Health Centers: Addressing Patients’ Health-Harming Civil Legal Needs as Part of Primary Care*, NAT’L CTR. MED.-LEGAL PARTNERSHIP, at 1 (Feb. 2015), <http://medical-legalpartnership.org/wp-content/uploads/2015/08/Medical-Legal-Partnership-and-Health-Centers.pdf> [https://perma.cc/2D6L-KUYJ].

avoid health crises, as well as legal crises.¹⁶⁰ For example, in 1996, out of concerns regarding the legal barriers facing some of the most vulnerable patients of University of New Mexico (UNM) community-based health clinics in Albuquerque, Dr. Andrew Hsi, MD, MPH, of the UNM School of Medicine and Professor Michael Norwood of the UNM School of Law founded the UNM Medical Legal Alliance (MLA).¹⁶¹ Seeking to reach children and families with intensive health and legal needs, the MLA integrated law students taking part in the law school's Community Lawyering Clinic into neighborhood pediatric and family medicine clinics in low-income communities.¹⁶² When those patients come to see the doctor, they can also see a law student to pursue legal assistance.¹⁶³

1. Individual Patient Advocacy

The "medical-legal partnership" model of advocacy involves a "train and treat" approach.¹⁶⁴ Attorneys train healthcare professionals to identify potential legal issues among their patients and refer them to lawyers, just as they would make referrals to other specialists to expand the treatment team. Then those lawyers, integrated into the healthcare setting, "treat" the patients through legal advocacy.¹⁶⁵ Under the MLA at UNM, law students and faculty train healthcare providers to identify and refer patients to the UNM Community Lawyering law clinic for free legal assistance.¹⁶⁶ Each semester, approximately sixteen Community Lawyering Clinic law students represent patients under faculty supervision in a broad range of legal areas such as family law, domestic violence, kinship guardianships, immigration, property disputes, disability law, and education.¹⁶⁷ By bringing health and legal professionals together to identify legal issues in a health clinic setting, the model often allows these providers to identify patients in need of assistance before crisis situations arise and the effects on health

160. See generally Lisa Pilnik, *Practicing Preventive Law: A Day in the Life of a Medical-Legal Partnership Attorney*, 27 CHILD L. PRAC. 14 (2008), <http://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/mlp.authcheckdam.pdf> [https://perma.cc/4SUC-JJJP].

161. Cannon & Hsi, *supra* note 42, at 48; see also *UNM Medical-Legal Alliance: 2013 Snapshot*, NAT'L CTR. MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/wp-content/uploads/2014/02/UNM-Medical-Legal-Alliance-2013-Albuquerque-NM.pdf> [https://perma.cc/4ZYX-EYC7]. Although the collaboration began informally in 1996, the MLAC was formally established in January 2007. *Medical-Legal Alliance for Children*, UNM LAW, Spring 2007, at 8. The MLAC is also known in shorthand as the UNM Medical Legal Alliance (MLA), which is how this Article refers to the partnership.

162. *Id.*

163. Cannon & Hsi, *supra* note 42, at 519.

164. Lawton et al., *supra* note 157, at 75.

165. *The MLP Response*, *supra* note 14.

166. April Land, "Lawyering Beyond" Without Leaving Individual Clients Behind, 18 CLINICAL L. REV. 47, 53 (2011).

167. *Id.*; Cannon & Hsi, *supra* note 42, at 64.

are worsened.¹⁶⁸

Many families like Selena's are patients of one of the MLA's core healthcare partners, the FOCUS clinic. FOCUS treats children born with positive drug toxicologies. Because those children have a parent who is a substance abuser, a form of trauma that is one of the ACE categories, those babies come into this world with an ACE.¹⁶⁹ The team screens each baby for other forms of childhood trauma, and for health and mental health needs. The team also screens the entire family for health and mental health needs, as well as legal needs. This type of comprehensive screening not only encompasses the core components of a Medicaid EPSDT well child check, but looks even more broadly at legal issues implicating the health and well-being of families who have suffered trauma. Once needs are identified, the MLA wraps health, developmental, mental health, and legal services around the child and family in the health clinic and the home, and refers the child for any additional needed services.¹⁷⁰

Similarly reflecting the inter-disciplinary medical-legal partnership model, the new Georgetown University Health Justice Alliance teams law students, fellows, and faculty with a health and behavioral health community pediatrics team to bring together diverse legal, mental health, and medical services to support families. The Alliance brings its holistic services directly to children who are a high risk of trauma, by locating health clinics and legal services directly where those families live and learn, in Washington, D.C.'s large emergency homeless shelter for children and families, within high schools in highly underserved neighborhoods, and through a mobile health clinic van that parks directly in communities where poverty and neighborhood are high.¹⁷¹

For Selena and her family, the medical-legal partnership model would have provided a very different experience at the doctor's office, one in which her well-child checks provided a gateway towards comprehensive screening of her holistic needs and connections to needed services early in life. At the UNM Medical Legal Alliance's FOCUS health clinic, for example, her healthcare team would have taken advantage of frequent Medicaid EPSDT well child checks to screen her comprehensively, including for mental health and developmental needs, using evidence-based screening tools as well as discussions with the family that reflect the healthcare team's training around issues of trauma, toxic stress, and their implications. Through these checks, the team would have identified the various forms of trauma that she experienced, such as the parental substance abuse in her

168. See Sandel et al., *supra* note 13, at 1698; Ellen M. Lawton & Megan Sandel, *Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership*, 35 J. LEGAL MED. 29, 38 (2010).

169. Cannon & Hsi, *supra* note 42, at 512–13.

170. *Id.* at 513–14.

171. Kat Zambon, *Doctors and Lawyers Speak Out for Health Justice Alliance*, GEO. U. MED. CTR. (Sept. 22, 2017), <https://gumc.georgetown.edu/news/Doctors-and-Lawyers-Speak-Out-for-Health-Justice-Alliance> [<https://perma.cc/SF86-Z5FL>].

household and the absence of her father due to incarceration. The team would have also identified developmental and mental health needs, such as any attachment challenges with which Selena is struggling as a result of being passed among family members frequently, which may necessitate mental health treatment. Her healthcare providers would have referred Selena for any more in-depth evaluations she may have required, such a comprehensive mental health evaluation by a psychologist.

Because FOCUS uses an inter-generational approach to care of these high-needs children, the healthcare team would have also assessed the needs of Joann and Amelia, and developed a holistic, multi-disciplinary plan for the family's care.¹⁷² If Amelia was still involved in Selena's life at the time, the team would have provided her with needed care, such as medication-assisted substance abuse treatment and referrals to counseling services to support her recovery from drug addiction. The team would have provided Joann and Amelia with support in parenting skills and home-based early intervention services to address any developmental delays experienced by Selena.¹⁷³

The healthcare team would also have referred the family to the Community Lawyering Clinic for legal services. Law students and faculty have trained the MLA's FOCUS team to identify potential legal issues that may arise for their patients, such as legal needs related to child custody, special education, and Medicaid appeals. When the FOCUS healthcare team spots a potential legal issue, they make a referral to the law clinic, and a law student, sometimes in partnership with a medical student, conducts a legal intake to assess the family's legal needs. If a need is identified, the law student might provide the family with legal advice, refer them to a legal services organization, or directly provide the family with legal representation.

For Selena's family, the legal services of the MLA may have been deployed in a number of ways to address their legal needs. For example, if the family experienced barriers like transportation that kept them from bringing Selena to the doctor for well-child checks or other appointments, the MLA could have advocated to ensure that transportation was provided for the family through Medicaid. If Amelia was unavailable to care for Selena, MLA law clinic students could have advocated for Joann to become Selena's legal guardian in order to achieve family stability and ensure that Joann could make educational and medical decisions on Selena's behalf during Amelia's absence.¹⁷⁴ The MLA could have advocated for appropriate special education services to address Selena's social-emotional needs and any other developmental needs that might necessitate special education programming as Selena entered school.¹⁷⁵ And as the healthcare team

172. *Id.*

173. *Id.* at 514.

174. See Kinship Guardianship Act, N.M. STAT. ANN. § 40-10B-1 *et seq.* (2016).

175. See Yael Cannon et al., *A Solution Hiding in Plain Sight: Special Education and Better*

recommended any medically necessary health or mental health services, law students could have advocated to ensure that those services were timely provided or appealed any denials of recommended services through an administrative hearing pursuant to Medicaid EPSDT law.¹⁷⁶ These forms of legal advocacy would have helped to provide stability and access to necessary services for Selena that could have set her on a better path towards improved physical health, mental health, educational, and family outcomes.

The different experience Selena would have had as a medical-legal partnership patient exemplifies the promise that collaborative patient advocacy can have to identify and address the complex needs of children who have suffered trauma. All children living in poverty should have access to attorney-physician teams. Attorneys should train healthcare providers on the Medicaid EPSDT rights of their patients and think collaboratively with healthcare teams about how to ensure that pediatric patients are screened comprehensively and connected to medically necessary treatment, including mental health treatment. Medical-legal partnerships provide a holistic, preventive framework that embraces early identification and intervention as problem-solving approaches for people living in poverty.¹⁷⁷ Consequently, health clinics that have adopted the MLP approach can provide leadership and best practices models for comprehensive screening for Medicaid-eligible children not only for health and mental health needs, as required by Medicaid EPSDT, but also for legal needs, which are often closely connected for children who have suffered trauma, like Selena.

Moreover, physicians discouraged from mental health screening of children by waitlists and scarcities of the mental health services they would ultimately recommend may feel more confident conducting the necessary screening for mental health services if they have access to attorneys who could help patients pursue any further evaluations or medically necessary services the physicians recommend. For example, the Medicaid EPSDT appeals process provides a concrete structure for this type of legal advocacy through a fair hearing.¹⁷⁸ Indeed, “[d]octors, who are in an ideal position to ask about systemic problems that affect the health of their patients are more likely to do so ‘if they have the support and expertise of a lawyer who can offer solutions or training in available remedies.’”¹⁷⁹

Outcomes for Students with Social, Emotional, and Behavioral Challenges, 41 *FORDHAM URB. L.J.* 403 (2015).

176. See 42 U.S.C. §1396a(a)(3) (2012) (requiring that Medicaid state plans “provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness”).

177. Sandel et al., *supra* note 13, at 1699 (“The first core component is providing legal advice and assistance to patients, with a focus on the early detection of legal problems and the prevention of legal crises and health consequences.”).

178. 42 U.S.C. §1396a(a)(3) (2012).

179. Monica Carmean, Note, *Medical-Legal Partnerships: Unmet Potential for Legislative Advocacy*, 19 *GEO. J. ON POVERTY L. & POL’Y* 499, 505 (2012)

When lawyers learn of these problems, they can advocate for the timely provision of required evaluations and services for individual patients. Those interventions by lawyers in individual cases can also help to ensure accountability for children's mental health systems and spur improvements as a result where state Medicaid systems and managed care organizations adopt improved practices in order to avoid further appeals.

2. Impact Litigation

When Medicaid EPSDT systems are broken, attorneys and physicians can take action not only through individual patient advocacy, but through broader impact litigation as well. Lawsuits to enforce Medicaid EPSDT in both the District of Columbia¹⁸⁰ and Massachusetts¹⁸¹ revealed a failure to provide eligible children with comprehensive screens. Citing the number of children not receiving screening services as evidence of noncompliance, the court in each case ordered the development of expansive monitoring systems to ensure that every child receives the screening services and follow-up care required. Focusing on the defendants' lack of "procedures to determine whether children receive the full battery of EPSDT screening services," the judge in D.C. ordered the city to "design and employ policies and methods to assure that children receive rescreening and treatment when due."¹⁸² Similarly, the court in Massachusetts focused on the need to monitor and assure that children with serious emotional disturbance "will necessarily receive these pediatric assessments at any particular time or in any consistent form."¹⁸³ Both courts also sought to ensure that providers had the necessary training to implement the required screens.¹⁸⁴

In Massachusetts, the attorneys who advocated on behalf of the aggrieved families partnered with physician experts to ensure that the court understood the unmet needs for mental health screening and medically necessary community-based mental health treatment for Medicaid-eligible children.¹⁸⁵ As a result of

180. *Salazar v. D.C.*, 954 F. Supp. 278, 304 (D.D.C. 1996), *amending* 938 F. Supp. 926 (D.D.C. 1996). For subsequent case history, see *Salazar v. D.C.*, No. CA-93-452(GK), 1997 WL 306876 (D.D.C. Jan. 17, 1997) (issuing remedial plan to ensure state compliance with EPSDT screening and informing requirements); *Salazar v. D.C.*, No. CA-93-452(GK) (D.D.C. Sept. 17, 2001) (ordering compliance with screening, adolescent targeting, provider outreach, and tracking requirements of settlement agreement); *Salazar v. D.C.*, 729 F. Supp. 2d 257 (D.D.C. 2010) (finding § 1396a(a)(43) enforceable under § 1983 and refusing to vacate consent decree).

181. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52 (D. Mass. 2006) ("For the majority of SED children in the Commonwealth, assessments take place in name, or not at all.")

182. *Salazar*, 954 F. Supp. at 307 (quoting CMS MEDICAID MANUAL, *supra* note 115, at §5310(A)).

183. *Rosie D.*, 410 F. Supp. 2d at 34.

184. *Id.* at 35; *Salazar*, 954 F. Supp. at 313, 328.

185. See Plaintiffs' Proposed Findings of Fact and Conclusions of Law, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (citing the testimony of healthcare providers in support of the proposed factual findings); Plaintiffs' Revised Witness List, *Rosie D. v.*

policy changes stemming from the Massachusetts litigation,¹⁸⁶ the state promulgated new EPSDT regulations to require providers to use one of a number of evidence-based behavioral health screening tools as part of a well child check.¹⁸⁷ Data suggests that this approach has increased both the rates at which Massachusetts Medicaid-eligible children receive behavioral health screenings¹⁸⁸ and behavioral health related outpatient services.¹⁸⁹

Medical-legal partnerships—when they have the resources and expertise and are not restricted by their funding sources¹⁹⁰—are well-poised to bring to light endemic issues in Medicaid EPSDT systems and improve children’s health and mental health systems through impact litigation cases like those brought in Massachusetts and D.C. As “[h]ealthcare providers are armed with clinical stories and medical evidence” that can support legal deficiencies in Medicaid EPSDT systems, such as inadequate screening and treatment programs, insufficient reimbursement rates for well-child checks, failures by state Medicaid agencies to ensure that physicians receive the necessary training and tools to conduct mental health screening, medical-legal partnerships can turn patterns identified in the examination room into systemic change. Physicians bring expertise, information, and credibility as witnesses when they collaborate with lawyers in litigation. In

Romney, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (listing many healthcare providers).

186. *Rosie D.*, 410 F. Supp. 2d at 22. Plaintiffs also charged defendants with violation of the “reasonable promptness” provision, the “equal access” provision, and “managed care provision” of the Medicaid Act. *Id.*

187. Defendants’ 8/29/06 Remedial Plan Proposal at 3, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199).

188. Mass. Screening Reports, *supra* note 130 (showing the percent of physician visits that included behavioral screenings increased from 14.22% in early 2008 to 68.01% in mid 2016); Karen Kuhlthau et al., *Increases in Behavioral Health Screening in Pediatric Care for Massachusetts Medicaid Patients*, 165 ARCHIVES PEDIATRICS & ADOLESCENT MED. 660, 662 (2011).

189. Karen Hacker et al., *The Impact of the Massachusetts Behavioral Health Child Screening Policy on Service Utilization*, 68 PSYCHIATRIC SERVS. 25, 29 (2017) (finding that the adjusted rate of behavioral health-related outpatient service utilization rose from approximately 35 per 1,000 youths per month to approximately 50 per 1,000 youth per month following implementation of the screening mandate); Sharon Rignwalt, *Developmental Screening and Assessment Instruments with an Emphasis on Social and Emotional Development for Young Children Ages Birth Through Five*, NAT’L EARLY CHILDHOOD TECHNICAL ASSISTANCE CTR. 5 (2008), <http://www.nectac.org/~pdfs/pubs/screening.pdf> [<https://perma.cc/R6FH-CMFR>] (finding increased formal screening rates were associated with a 10.1 percent increase in the number of children receiving behavioral health services within 6 months of a well-child visit).

190. “Because of Legal Services Corporation (‘LSC’) funding restrictions on certain activities that focus on systemic change (including prohibitions against class action lawsuits and legislative lobbying), some programs that accept LSC funding may not engage in social change advocacy at all.” Tobin Tyler, *supra* note 14, at 240 (discussing the challenges facing legal services programs in engaging in social change advocacy to address social determinants of health). In New Mexico, attorneys from some legal advocacy organizations have expressed concerns about the need for Medicaid EPSDT systems change to ensure mental health screenings and treatment are provided as required by law and have been trying to work collaboratively with state agencies to improve the system without yet resorting to impact litigation as a strategy.

individual patient cases and larger impact cases alike, MLPs “bring a uniquely powerful clinical voice to the advocacy process”¹⁹¹ to ensure that Medicaid-eligible children receive the mental health screenings and treatment to which they are entitled.

B. Transforming Healthcare and Legal Institutions by Training the Next Generation of Leaders in Law and Medicine in Early Identification of Children’s Mental Health Needs

“Concerns that traditional legal and medical education have emphasized technical skill and practice management over problem-solving and the professional relationship have led to calls for major reforms in the way we educate doctors and lawyers . . . medical-legal partnership in the academy can offer a rich opportunity to bring future doctors and lawyers together to explore issues of social justice and professional ethics, as well as to practice interdisciplinary collaboration and problem-solving.”¹⁹²

MLPs transform health care practice by training providers to both understand and identify social determinants of health and to play an active role in addressing unmet legal needs.¹⁹³ Physicians feel empowered to ask questions about social determinants of health because they finally have a solution to the problems they uncover in the form of integrated legal care. Legal institutions are also transformed because the model allows for early detection of legal barriers in the examination room, when they may still be burgeoning, rather than in the courthouse, for example, when crises have typically escalated. In this way, the MLP model reflects the early identification ethos of Medicaid EPSDT and indeed of primary care as a whole.¹⁹⁴

The adoption of this approach not only allows attorneys to be more preventive, but presents a unique access to justice model, where “legal services are delivered to vulnerable populations by identifying legal needs within a trusted health care setting, rather than waiting for potential clients to seek out assistance at a local legal aid office.”¹⁹⁵ The same way that many health clinics have become part of the fabric of communities in order to create improved access to healthcare, by

191. Sandel et al., *supra* note 13, at 1699.

192. Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL’Y 249, 276 (2008).

193. Tobin Tyler, *supra* note 14, at 235.

194. Ellen Lawton et al., *supra* note 157, at 72 (“A patient might not have enough food, which is frequently seen as a ‘social’ need. But when that patient is wrongly denied Supplemental Nutrition Assistance (SNAP) benefits- formerly known as food stamps- what was a social need becomes a legal need because access to the benefit is prescribed by law With a focus on early detection of legal problems and prevention of legal and health crises, MLP legal practice is frequently understood as analogous to primary care.”)

195. *Id.* at 236.

embedding in community-based health clinic settings, legal aid offices are creating even greater access to justice by taking legal services to clients in clinics where they already go to seek out healthcare.

MLPs also provide a broader paradigm shift for health and legal institutions in the way that they approach the people they serve; rather than operating in silos, lawyers and doctors serving people living in poverty can come together to holistically identify patient/client needs and develop collaborative solutions. Services that were fragmented become coordinated, and the patient/client now has a team in their corner. And patient and client care takes on new meaning when both health and justice implications are considered with individuals and families as they make critical decisions and seek out supports from both legal and health institutions.

Academic medical-legal partnerships present great promise for health and legal institution transformation by influencing and changing the way providers in both realms are trained from the beginning, before they even take on their first patient or client. In university-based MLPs, law students come together with students of health disciplines such as medicine, nursing, public health, and social work to learn collaboratively about social determinants of health and the potential for collaboration to address those barriers.¹⁹⁶ Through the UNM MLA, law and medical school faculty train their students and medical residents—future leaders in law and medicine, many of whom will shape policy in their careers—to understand the ACEs research, including the prevalence of childhood trauma and the poor health and legal outcomes that the data indicates are likely. Law students engage in an exercise called “ACEs in Your Cases,” in which law and medical school faculty guide them through screening individuals in their cases for trauma histories, considering the health and justice implications, and developing plans for advocacy on behalf of their clients that are informed by an understanding of trauma and mental health needs. Students and residents also learn about Medicaid EPSDT and the platform it provides for screening for mental health needs and access to medically necessary treatment.¹⁹⁷

At Georgetown University’s Health Justice Alliance, medical students and

196. Elizabeth Tobin Tyler et al., *Medical-Legal Partnership in Medical Education: Pathways and Opportunities*, 35 J. LEGAL MED. 149, 164 (2014). Note that while some academic MLPs like those at Georgetown University and University of New Mexico bring law and medical students together, some academic MLPs engage law students with healthcare providers at community health centers or hospitals, but not medical students, such as where a university has a law school but no medical school with which to partner. Other MLPs engage medical students and residents with attorneys at legal services organizations, but do not engage law students through a law school course.

197. The Toledo Medical-Legal Partnership for Children has also created a PowerPoint to train healthcare providers on EPSDT, including how they can identify when a patient has a legal need for services as a result of, for instance, a lack of necessary prior authorization. See David Koeninger et al., *Current State of Health Coverage for Kids: What You Should Know About the ACA, EPSDT, and How to Get Pediatric Patients the Care They Need*, TOLEDO MED.-LEGAL PARTNERSHIP CHILD (on file with author).

law students participate in a joint seminar to learn about the long-lasting effects of childhood trauma on health and justice outcomes, and consider how physicians and attorneys can collaborate to disrupt that path.¹⁹⁸ They also learn about childhood trauma and the structure of Medicaid EPSDT law. At a free clinic located in a family homeless shelter, medical students provide patients with a legal check-up as part of their health visit. When legal issues are identified, law and medical students address those legal barriers to health for the highly traumatized population at the shelter, and work to ensure that holistic health and legal needs are identified and timely addressed to prevent further crises in the lives of these parents and children.¹⁹⁹

The UNM MLA also immerses medical and law students intensively in the classroom and the field advocating on behalf of traumatized families. Fourth year medical students participate in community ambulatory clinical rotations in the law school's Community Lawyering Clinic. The medical students join classroom discussions on advocacy skills, ethics, and social justice values. They participate in legal intakes, transforming the legal interview into a collaborative, holistic problem-identification and problem-solving session by a medical student/law student team. Medical students come to court and participate in and observe other case events. And law and medical students come together for a type of troubleshooting and problem-solving critical to both law and medical education—case rounds.²⁰⁰ In case rounds in the Community Lawyering Clinic, law and medical students discuss the challenges facing traumatized children and families in their cases, work through various dimensions of the problem, develop possible solutions, and begin to make a plan for next steps.²⁰¹ Students from the law and medical schools work to improve the lives of traumatized children and their families by advocating to remove legal barriers to health, ensuring family stability and access to necessary health, disability, and educational services.

In addition to furthering patient wellbeing, academic MLPs provide these unique benefits to the students and ultimately to the communities they will serve. By learning to understand the connection between patients' health problems and social determinants, future physicians learn how to show socioeconomic and

198. See *Georgetown University Health Justice Alliance*, GEO. U. L., <https://www.law.georgetown.edu/academics/centers-institutes/health-justice-alliance> [<https://perma.cc/PDN4-2BW2>].

199. See *HOYA Clinic*, GEO. U. MED. CTR., <https://hoyaclinic.som.georgetown.edu> [<https://perma.cc/UUA9-TES3>].

200. Muhammad Ali Abdool & Don Bradley, *Twelve Tips to Improve Medical Teaching Rounds*, 35 MED. TCHR. 895, 895 (2013) (noting that bedside rounds, senior clinician-guided reviews and presentation of patients' notes, signs and symptoms, teach students the clinical and communication skills necessary to be a doctor); Elliot S. Milstein, *Clinical Legal Education in the United States: In-House Clinics, Externships, and Simulations*, 51 J. LEGAL EDUC. 375, 377 (2001) (describing case rounds as student presentations of cases either in preparation for group decision-making or as updates on the status of active cases).

201. Milstein, *supra* note 200, at 377.

cultural sensitivity, communicate effectively to a diverse patient population, become patient advocates, and work as members of an inter-professional team – all skills that could benefit Selena and other traumatized children and their families in the examination room and on a policy level.²⁰² By connecting theory and practice through direct client interaction, law students gain experience in translating medical and technical information into legal standards²⁰³ and learn the importance of social justice values, cross-cultural competence, and effective communication.²⁰⁴ As a result, they can better advocate on behalf of families like Selena’s through individual representation and inter-professional collaboration to develop policy solutions that disrupt the trajectory from trauma to poor health.²⁰⁵

Through training the next generation of leaders in law and medicine to understand childhood trauma and its implications and the promise of Medicaid EPSDT to address these issues preventively, we can begin to transform policies and systems. Many law and medical students will go on to become key policy and decision-makers in their roles leading government agencies, serving as judges and legislators, and running healthcare systems and hospitals, for example. Both medical and legal education are often heavily focused on developing technical skills. Academics collaborations such as the MLA challenge students to consider health and justice problems in their social contexts and broaden their concepts of professional roles and limits.²⁰⁶

When these medical and law students graduate and move into their respective professions, medical and legal institutions will be transformed by their more holistic approaches to complex patient problems. Learning about the effect of childhood trauma and lifelong outcomes can prompt a nurse, a physician, an attorney, or a judge to ask not “what’s wrong with this person?” but instead “what happened to this person?”²⁰⁷ This change in perspective that should be cultivated in law and medical education represents a critical shift in the way that hospitals and courts may think about some of the most complex people who come through their doors. Perpetrators of crime and super-utilizers of medicine may in fact have been traumatized children whose trajectory could have been improved by earlier identification and intervention around mental health needs. Medical students will think about trauma and mental health in the patient room, and may feel more empowered to embrace the holistic vision of Medicaid EPSDT or to voice the barrier they face in its implementation. Lawyers will become more trauma-

202. Paul et al., *supra* note 151, at 206 tbl.1.

203. Wettach, *supra* note 10, at 311.

204. Emily A. Benfer, *Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education*, 35 J. LEGAL MED. 113, 138 (2014).

205. Tobin Tyler et al., *supra* note 196, at 161.

206. Tobin Tyler, *supra* note 192, at 271.

207. See Nadine Burke Harris, *How Childhood Trauma Affects Health Across a Lifetime*, TED: IDEAS WORTH SPREADING, https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime [https://perma.cc/Q62A-J3WD].

informed and push government systems like Medicaid and school districts in the direction of early identification and intervention. Engaging with these complex issues in the classroom and advocating on behalf of families in the field allows for students to bring health and justice perspectives to policy gaps and begin their careers with an eye towards collaborative and holistic problem-solving at the individual and population levels.

C. Mobilizing Towards Policy Change

“Individual cases develop a practitioner’s sense of broader concerns or trends in a community. It is often a recurrent problem seen as a pattern across many patients that triggers the need for policy action rather than individual attention. MLP develops both perspective and relationships that can facilitate the steps to influence policy.”²⁰⁸

In addition to the direct legal care provided to patients, medical-legal partnerships are well-situated to advocate more systemically for changes to policies that result in injustice and poor health for underserved patients.²⁰⁹ MLPs are uniquely positioned to effectuate policy change because they combine the understanding on the part of medical professionals of the adverse health implications of specific conditions and policies with the capacity of lawyers to navigate decision-making systems and develop and advocate for proposed policy changes.²¹⁰ For example, attorneys and physicians in Boston saw many patients after with critical health issues, who were dependent on electricity for oxygen tanks and insulin refrigeration, suffering from utilities shut-offs in their homes. They worked together to successfully reform public benefit and utility regulations to protect patients from these harmful utility shut-offs.²¹¹ By collaborating with attorneys, medical providers can gain insight into the laws and policies that affect patient health and develop legal and policy remedies. Similarly, by partnering with health professionals, lawyers learn to reframe their advocacy in terms of health and

208. Manel Kappagoda et al., *Public Health Crisis: Medical-Legal Partnership Approaches to Obesity Prevention*, in *POVERTY, HEALTH, AND LAW* 601, 636 (Elizabeth Tobin Tyler et al. ed., 2011).

209. See, e.g., Daniel Atkins et al., *Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy*, 35 J. LEGAL MED. 195 (2014); Barry Zuckerman et al., *From Principles to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health*, 92 ARCHIVES DISEASE CHILDHOOD 100 (2007).

210. See Zuckerman et al., *supra* note 209, at 101. Despite the growing body of literature discussing the impact of MLPs through the individual legal representation of patients provided by attorneys in healthcare settings, there has been relatively little written about the impact of MLPs on policy change. There is a need for more scholarship exploring the role of MLPs in systemic advocacy towards policy change. Tishra Beeson et al., *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*, NAT’L CTR. MED.-LEGAL PARTNERSHIP 8 (Feb. 2013), <http://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf> [<https://perma.cc/D8CZ-VN7U>].

211. Beeson et al., *supra* note 210, at 4; Zuckerman et al., *supra* note 12, at 226; Sandel et al., *supra* note 13, at 1701–02.

well-being and rely on the science-based perspectives—and credibility—of their medical partners to substantiate their arguments.²¹²

1. Research and Data to Educate Policymakers

While teaching and supervising law and medical students in advocacy on behalf of traumatized children and their families, MLA co-founder Dr. Hsi and I, along with other law and medical school faculty members, confronted repeatedly a challenge that we sought to better understand. Young children like Selena would come through our doors, and we would see before our eyes the pathway from childhood trauma to poor health, mental health, and justice outcomes. As they grew older, young children like Selena who had experienced trauma would get in trouble at school, and quickly get entangled in the school-to-prison pipeline,²¹³ facing punishment at school and in the juvenile justice system. Many of their older siblings were involved in the delinquency and criminal justice systems as well. And the inter-generational nature of these cycles was striking; many of their parents had experienced trauma in childhood and now were struggling with addiction, mental health needs, and involvement with various legal systems. The Community Lawyering Clinic law students also represent youth in delinquency matters in the county's Children's Court²¹⁴ through a partnership with the public defender office's juvenile division. In that work, my students, my colleagues, and I also got a glimpse into the trauma histories of many of these teenagers, who were now in court facing charges in the delinquency system. We witnessed firsthand the pathway from early childhood trauma to poor health and delinquency outcomes.²¹⁵

Along with our medical school colleagues, we hoped that New Mexico, a state consistently ranked at the bottom of the nation in childhood well-being,²¹⁶ could prioritize the issue of childhood trauma and develop policies to disrupt the trauma-to-juvenile and criminal justice pipeline through more preventive and early intervention approaches. Dr. Hsi and I resolved to find a way to educate policymakers in New Mexico about these critical unmet needs and unmask the dimensions of these problems in our state. We collaborated with Dr. George Davis,

212. Megan Sandel et al., *Medical-Legal Partnership: Strategies for Policy Change, in Poverty, Health and Law*, in *POVERTY, HEALTH, AND LAW: READINGS & CASES FOR MEDICAL-LEGAL PARTNERSHIP* 581, 594 (Elizabeth Tobin Tyler et al. eds., 2011).

213. The phrase "school-to-prison pipeline" refers to the increasingly punitive school systems that push minority students out of school and the parallel shift in juvenile justice that make it easier to try juveniles as adults, strengthen sanctions, and reduce confidentiality provisions for juveniles. Johanna Wald & Daniel Losen, *Defining and Redirecting a School-to-Prison Pipeline*, 99 *NEW DIRECTIONS STUDENT LEADERSHIP* 9, 11 (2013).

214. N.M. STAT. ANN. §§ 32A-2-1 to -33 (West 2016).

215. See Cannon & Hsi, *supra* note 42.

216. *Kids Count Data Book: State Trends in Child Well-Being*, ANNIE E. CASEY FOUND. 19 (2016), <http://www.aecf.org/m/resourcedoc/aecf-the2016kidscountdatabook-2016.pdf> [<https://perma.cc/K5DN-CXLF>].

MD the director of psychiatry for the state's Children, Youth, and Families Department (CYFD), the executive branch agency charged with overseeing both the state's child protective services and juvenile justice systems, and with Alexandra Bochte, a recent Community Lawyering Clinic law student graduate, to examine the trauma histories of youth incarcerated in the state's juvenile justice facilities. We knew from our collective work that youth incarcerated in state juvenile justice facilities in New Mexico—those for whom community-based interventions had failed or were deemed insufficient for safety or other reasons²¹⁷—were in fact some of the most traumatized youth in the state. Our individual cases, which were identified in the health setting, served “as diagnostic tools for failed policies.”²¹⁸ We resolved to study the problem to provide an evidence base to inform policy change. The unmet needs of our patients and clients informed our thinking about policy reform. Decision-makers in all three branches of government needed to know that without early identification and intervention, traumatized children were becoming incarcerated youth, at great cost to them, their families, and taxpayers.²¹⁹

Dr. Davis' team had developed a process for providing psychosocial evaluations to every youth committed to the custody of the state's CYFD juvenile justice facilities during their intake at the state's Youth Development and Diagnostic Center. The evaluation involved independent intake interviews of the youth by psychological diagnosticians and information gathered from juvenile justice, medical, educational, and child protective services records, as well as from guardians and probation officers.²²⁰ These evaluation reports provided great insight into the trauma histories of those who had been deemed the state's most serious juvenile offenders. Building on MLP principles, our collective law, pediatric, and psychiatric backgrounds brought a unique analysis to this problem of childhood trauma and its connected outcomes. Working together, our various perspectives could enrich the development of policy solutions, and we sought to employ a multi-disciplinary framework that draws on the medical-legal partnership approach to understanding health and justice inequities not only on the ground but at the policy level.²²¹ By partnering health care providers and lawyers in our study and analysis

217. N.M. STAT. ANN. § 32A-2-19(B) (2016) (describing the court's authority under the New Mexico Children's Code to commit youth who have been adjudicated delinquent to a facility for their care and rehabilitation).

218. Lawton & Sandel, *supra* note 168, at 38.

219. In 2015, the cost of confinement per youth in a state juvenile facility was \$182,000. State of N.M. Legislative Fin. Comm., Report No. 16-06, Program Evaluation: Effectiveness of Juvenile Justice Facilities and Community-Based Services 21 (2016), <https://www.nmlegis.gov/handouts/ALFC%20082416%20Item%204%20Program%20Evaluation%20-%20%20Effectiveness%20of%20Juvenile%20Justice%20Facilities%20and%20Community-Based%20Services.pdf> [<https://perma.cc/3ZBC-N2FS>].

220. Cannon et al., *supra* note 28, at 4.

221. See Kappagoda, *supra* note 208, at 636 (describing how the origins of medical-legal partnerships “lie in providing individual patients and clients with integrated medical and legal care

of this problem, we hoped to shine a spotlight on policy failures that were otherwise going undetected.²²²

The New Mexico Sentencing Commission was a unique and important partner for the research and publication of the study. The Commission assists the executive, legislative, and judicial branches of state government, as well as concerned citizens, in the analysis and development of “criminal and juvenile justice policy.” The Commission is comprised of representatives from the executive and judicial branches of state government, “legislators’ appointees, law enforcement officials, criminal defense attorneys, and citizens.”²²³ As a result, the Commission’s reports gain the attention of key stakeholders and decision-makers, and the entity is a critical player in criminal and juvenile justice policymaking in New Mexico. The Sentencing Commission brought another disciplinary perspective, with staff skilled in statistical analysis, as well as juvenile justice policy analysis. It also provided a platform for our research to go beyond an academic exercise to draw upon our unique inter-disciplinary analysis of these challenges and our patient/client stories from our medical-legal partnership work to inform policymakers across the three branches of government about the problems we had identified on the ground.

The resulting study, *Adverse Childhood Experiences in the New Mexico Juvenile Justice Population*, aimed to (1) define the relationship between early childhood trauma and juvenile delinquency, (2) evaluate ways in which the law and medicine can facilitate better health and delinquency outcomes for children with ACEs, and (3) compare the prevalence of ACEs in New Mexico’s juvenile justice population with national prevalence in similar populations.²²⁴ We reviewed the psychosocial evaluations of all 220 youth aged thirteen to eighteen committed for incarceration in New Mexico in 2011,²²⁵ and applied the ACEs framework described above in Part I, assessing those youth for prevalence of the following nine ACEs: emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, household substance abuse, household mental illness, parental separation or divorce, and having an incarcerated household member.²²⁶

The data revealed that *all* female, and nearly all male, juvenile offenders were traumatized in childhood, having each experienced at least one ACE. Both male and female youth had a very high likelihood of having experienced physical neglect, emotional neglect, household substance abuse, and parental divorce or

to address the social determinants of health. However . . . both lawyers and healthcare providers can play a very powerful role as agents for policy change. Individual cases develop a practitioner’s sense of broader concerns or trends in the community.”)

222. Tobin Tyler, *supra* note 14, at 237.

223. *New Mexico Sentencing Commission*, U.N.M., <https://nmsc.unm.edu/index.html> [<https://perma.cc/63S3-TUGB>].

224. Cannon et al., *supra* note 28, at 1.

225. *Id.* at 4.

226. *Id.* at 1, 4.

separation.²²⁷ Ninety-four percent of the youth had experienced physical neglect, which included one hundred percent of the females studied.²²⁸ The study also concluded that youth in the New Mexico sample had a much greater probability of experiencing at least one ACE, and greater than four ACEs, as compared to their peers in other states.²²⁹ Twenty-three percent of females in particular experienced *all nine* ACEs (compared to only three percent of males).²³⁰ As described above, the field of ACEs research shows that those who have experienced more ACEs in childhood are more likely to have poor health conditions and exhibit risk behaviors. Specifically, most research stemming from the original ACEs study by the Kaiser Foundation and the CDC looks at the rates of health risks and poor health outcomes among individuals who experiences four or more ACEs, who are much more likely to experience depression or alcoholism, for example.²³¹ The ramifications for a person who has experienced *nine* ACEs, like many of the youth in our New Mexico juvenile justice study, seem potentially astounding.

With 86% of incarcerated youth in New Mexico having experienced four or more ACEs (rates seven times higher than the general population group studied by the CDC and Kaiser), it is not surprising that the youth studied in New Mexico experienced very high rates of psychological and substance abuse disorders.²³² For example, more than ninety-nine percent of the incarcerated youth (nearly every single one) met criteria for a mental health diagnosis and a substance abuse disorder.²³³ Depression in particular was widespread.²³⁴

With these findings in hand, we made recommendations for policy solutions to address these issues. We recommended that the state build on ongoing efforts to develop a strong, well-organized process to screen juvenile offenders entering the justice system for trauma, mental health conditions, and substance abuse disorders to help identify needs and target assistance.²³⁵ At the very least, such screening would fill the gap where Medicaid EPSDT well child checks had failed to catch those needs. We also recommended that the state employ evidence-based trauma treatment modalities for youth in the juvenile justice system, as well as youth returning home from state facilities, and train its juvenile justice system staff and community providers in trauma-informed care.²³⁶ Trauma screenings and trauma-informed treatment are increasingly common recommendations nationally, given the growing recognition of trauma and maltreatment histories among youth

227. *Id.* at 6 fig.3.

228. *Id.* at 5.

229. *Id.* at 6.

230. *Id.* at 6 fig.3.

231. *Id.* at 3.

232. *Id.* at 1.

233. *Id.* at 11 tbl.1.

234. *Id.*

235. *Id.* at 8.

236. *Id.* at 9.

involved in the juvenile justice system.²³⁷

We could not ignore our experience engaging in health and legal care in the community and our understanding of gaps in early identification and treatment of trauma and mental health needs. Therefore, we also recommended that the state enact policies to ensure that trauma, and the related physical and mental health needs of families and children, are identified early to decrease overall ACE rates and resultant negative health consequences.²³⁸ We described our MLA work in the primary care health setting as an example of a collaborative best practice towards trauma identification and improved health and justice outcomes, and explained the importance of mental health screening during Medicaid EPSDT well child checks.²³⁹

In addition to making our recommendations in writing in the New Mexico Sentencing Commission's publication, we took our findings and proposed solutions to all three branches of government. In regards to the executive branch, the Children, Youth, and Families Department (CYFD) joined our study as a formal partner in the project, supporting Dr. Davis' examination of the trauma needs of the state's juvenile justice population. We drew on our medical-legal partnership expertise in trying to inform the state agency's policies, especially as MLPs "have had substantial impact in improving regulatory implementation of health-related policy when both medical and legal practitioners meet with agency administrators."²⁴⁰ We testified alongside the Secretary of CYFD before the state's Legislative Health and Human Services Committee to discuss our findings and recommendations. Our testimony provided a unique opportunity to educate lawmakers about this problem, especially as we were able to draw on our interdisciplinary patient/client experiences and perspective, as well as concrete data from the study, to raise awareness of the serious depth of the trauma histories of our juvenile justice population and the implications of this trauma. Finally, we met with judges from Bernalillo's County Children's Court, a court which hears many of the juvenile justice cases in New Mexico and commits some of the state's most serious juvenile offenders to the custody of CYFD for incarceration in state facilities. We shared our findings and recommendations, and discussed policy implications for the judicial branch as well as for broader systemic changes the state could embrace.

With all three branches of government, our research—validated and analyzed by the New Mexico Sentencing Commission, which itself is connected to all three branches of government—was critical to gaining the attention and respect of policymakers. In line with MLP principles, the interdisciplinary nature of our team also helped to establish our credibility, as well as our combined academic and

237. Cannon & Hsi, *supra* note 42, at 36–38

238. Cannon et al., *supra* note 28, at 7.

239. *Id.*

240. Sandel et al., *supra* note 13, at 1699.

community-based experiences. The research findings set the stage for our policy recommendations aimed at early and regular screening and intervention to curve the dire trajectory painted by the statistics. As part of our testimony, we discussed the work of the MLA in addressing these issues in primary care settings. We described the power of Medicaid EPSDT well child visits to ensure an avenue for screening and identification of treatment needs for a large population in New Mexico, the state with the highest rates of children born into Medicaid families in the nation.²⁴¹

The study and resulting policy recommendations caught the eye of Raúl Torrez, the District Attorney (D.A.) for Bernalillo County, where Albuquerque, the largest metropolis in the state, is located. The data demonstrated to the D.A., who oversees the county's criminal prosecutors, that early childhood trauma is a "driver of crime in the community."²⁴² Citing to the study's findings, D.A. Torrez launched a partnership with the private and nonprofit sectors to work towards "the prevention and mitigation of early childhood trauma as part of a long-term strategy to improve not only public health, but public safety."²⁴³ The initiative, known as Mission Families,²⁴⁴ involves a collaboration with the United Way of Central New Mexico to identify and stabilize families more preventively and through early interventions "to help our most vulnerable children stay in school, stay out of the criminal justice system and become productive members of the community."²⁴⁵ An Advisory Council will develop "strategies that will increase prospects for secure and stable homes for children, improve children's safety and well-being, and support working families and student success from cradle to career."²⁴⁶ The D.A. encouraged other elected officials, leaders in the business community, and citizens to look at the data and "do more for traumatized children who need our help today, before they give rise to the public safety crisis of tomorrow."²⁴⁷

The MLP strategy of inter-disciplinary research to inform policy worked: the

241. Seventy-two percent of children born in New Mexico are born into families covered by Medicaid. See *Births Financed by Medicaid*, KAISER FAM. FOUND., <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22%25%20Births%20Financed%20by%20Medicaid%22,%22sort%22:%22desc%22%7D> [https://perma.cc/VF3L-RVE5]; Rick Nathanson, *New Mexico Has Highest Rate of Medicaid-Covered Births*, ALBUQUERQUE J. (Mar. 28, 2017), <https://www.abqjournal.com/977267/nm-has-highest-rate-of-medicaidcovered-births.html> [https://perma.cc/LEH4-5VBQ].

242. Raúl Torrez, *Securing the City: Broad Strategy Can Improve Law Enforcement and the Legal System*, ALBUQUERQUE J., November 19, 2017, http://ejournal.abqjournal.com/popovers/dynamic_article_popover.aspx?artguid=b99ebed9-bb3e-48cf-8ee8-21f62cca2003 [https://perma.cc/2233-5WA4].

243. *Id.*

244. Bernalillo County DA, *Mission: Families*, Vimeo (Nov. 2017), <https://vimeo.com/240023183?ref=em-v-share> [https://perma.cc/ZL4Z-36A4].

245. Torrez, *supra* note 242.

246. Bernalillo County DA, *supra* note 244.

247. Torrez, *supra* note 242.

prosecutors' office charged with enforcing law and order in a city with rising property and violent crimes²⁴⁸ began to pay attention to childhood trauma and change policy as a result of findings identifying significant ACEs histories among incarcerated youth and agreement with the authors' recommendations for a prevention focus. It is remarkable to see a prosecutors' office adopt a holistic approach accounting for public health needs, a further reflection of the power of the MLP paradigm. Indeed, the first program the D.A. intends to focus on cultivating as part of this new initiative is a new component of the UNM Medical Legal Alliance focused on serving youth in the juvenile justice system holistically, with an eye towards their health *and* behavioral health, developmental, and educational needs.²⁴⁹

We also incorporated our study findings into our teaching of law students, medical students, residents, and other healthcare professionals connected to the MLA. The study provides our students with a concrete understanding of the health and justice implications of trauma in New Mexico, and a platform for considering policy initiatives aimed at addressing the related problems, including the ways in which Medicaid EPSDT could provide an opportunity to identify these issues and intervene early on in a child's life. One of our law students who helped us with important research on the health and justice implications of childhood trauma ended up playing a key role as a recent law graduate as a co-author of the study.

As we explain to our students, our study confirmed our anecdotal experiences working with patients and clients on the ground, that our "delinquent" youth are in fact our traumatized youth. As a lawyer, I helped my pediatrician and psychiatrist partners to see the power of their voice and their patient stories in the advocacy process. Indeed, "as advocates, health care providers are armed with clinical stories and medical evidence of the impact of [social determinants of health] on patient health. Their voice in policy debates may be critical to convincing policymakers that change is needed."²⁵⁰ Our research, which built upon the advocacy on behalf of patients and clients discussed above in Part III(A), allowed us to pursue a core MLP strategy—providing evidence to support our recommendations for policy improvements.²⁵¹ Collaborative inter-disciplinary research efforts are needed to understand the impact of childhood trauma, gaps in Medicaid EPSDT implementation, and barriers for patients and physicians to the implementation of mental health screening in well child checks. Research across disciplines can yield concrete ideas for policy changes needed to close those gaps, such as increased

248. *Rising New Mexico Crime Rates Propelled by Albuquerque*, U.S. News and World Report at <https://www.usnews.com/news/best-states/new-mexico/articles/2017-09-26/rising-new-mexico-crime-rates-propelled-by-albuquerque> [<https://perma.cc/6X8V-CYGQ>].

249. Interview with Raul Torrez, Dist. Atty., Bernalillo Cty., in Washington, D.C. (Nov. 13, 2017).

250. Tobin Tyler *supra* note 14, at 237

251. *Id.* at 236

reimbursement rates and training for primary care providers in mental health screening, transportation services to well-child checks, and evidence-based mental health services that must be made more available for particular populations when treatment needs are identified, and can spark discussion and ultimately change among policy-makers and courts.

2. Policy Development through Inter-Disciplinary Coalition Engagement

Physicians and attorneys can also engage in coalitions in their communities to inform thoughtful policy change. For example, a judge in the District of Columbia provides oversight of the children's Medicaid system as a result of that long-running lawsuit alleging, among other legal violations, that the city has failed to provide children with required Medicaid EPSDT screenings.²⁵² Unfortunately, court oversight has had little effect on the city's fulfillment of its EPSDT screening requirements.²⁵³ More recently, however, an interdisciplinary coalition has spearheaded significant change. In 2012, the D.C. Collaborative for Mental Health in Pediatric Primary Care (D.C. Collaborative) was established, which is a public-private partnership²⁵⁴ that has worked to ensure that pediatricians get reimbursed for the extra time involved in conducting a mental health screening.²⁵⁵ The D.C. Collaborative spent 15 months training the pediatric providers that serve 80 percent

252. *Salazar v. D.C.*, 954 F. Supp. 278 (D.D.C. 1996), *amending* 938 F. Supp. 926 (D.D.C. 1996).

252. *Salazar*, 954 F. Supp. at 280.

253. For fiscal year 2015, the District's participation ratio – the number of Medicaid-eligible children who received at least one initial or periodic screening service divided by the number of Medicaid-eligible children who should have – was 63 percent, a 1-point decrease from pre-trial rates. *EPSDT 2015 Participation Report*, *supra* note 129. It should be noted that there was some improvement in the intervening years. The District achieved an 81 percent participant ratio in both 2010 and 2011. *Annual EPSDT Participation Report: Fiscal Year 2010*, CTRS. MEDICARE & MEDICAID SERVS. (Nov. 19, 2014), <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2010-epsdt-data.zip> [<https://perma.cc/HR4M-8K7V>]; *Annual EPSDT Participation Report: Fiscal Year 2011*, CTRS. MEDICARE & MEDICAID SERVS. (Jan. 7, 2014), <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2011-epsdt-data.zip> [<https://perma.cc/F8NM-P3KB>].

254. The D.C. Collaborative includes that includes the Children's National Health System, MedStar Georgetown University Hospital, the Children's Law Center, the D.C. Chapter of the American Academy of Pediatrics, the D.C. departments of Behavioral Health and Health Care Finance, and a community advisory board. *Evaluating DC's Progress in Meeting Children's Mental Health Needs: 2016 Children's Mental Health*, CHILD. L. CTR. 2 (May 2016), http://www.childrenslawcenter.org/sites/default/files/Childrens_Law_Center_MH_Update_2016.pdf [<https://perma.cc/2FJG-A6C6>] [hereinafter *2016 Update*]. It should also be noted that this increase coincided with a 2015 change in billing guidance that increased the rate for components of a well-child visit, including separately billed mental health screens. Memorandum from Claudia Schlosberg, Acting Senior Deputy Medicaid Dir., to D.C. EPSDT/HealthCheck Providers, EPSDT Well-Child Visits: New Billing Requirements and Rate Changes, Transmittal #14-29 (Oct. 2, 2014), <https://www.dchealthcheck.net/documents/Transmittal%2014-29.pdf> [<https://perma.cc/TXH6-43DA>].

255. *2016 Update*, *supra* note 254, at 2.

of all low-income children on Medicaid in D.C. on how to conduct mental health screenings. They also launched the Mental Health Access in Pediatrics project (DC-MAP) to give pediatricians the tools necessary to themselves treat some children with mental health issues and to provide quality referrals for those who require additional services.²⁵⁶ In part through provider training and the implementation of standardized mental health screening tools into 10 primary care practices, this coalition, funded in part by the D.C. government, was able to increase the mental health screening rate amongst the practices by over 70%.²⁵⁷

In 2014, the District also amended its billing requirements and reimbursement rates for well-child visits.²⁵⁸ In order to improve the documentation and tracking of EPSDT visit components, the new guidelines mandate that health care providers bill for the age-specific preventive medicine visit and bill for each screening component separately.²⁵⁹ Accordingly, providers now have a monetary incentive to conduct screenings as part of the well-child visits.²⁶⁰ Between 2013 and 2015, the number of developmental and behavioral health screens of children in D.C. rose more than four-fold from 5,020 to 22,762.²⁶¹ The policy changes in D.C. and the inter-disciplinary coalition that helped to achieve them draw upon the MLP

256. *Id.*

257. See Children's National, *Mental Health Screening in Pediatric Primary Care: Results from a Quality Improvement Learning Collaborative* (April 2016), https://www.sbm.org/UserFiles/file/Symposium50_Godoy.pdf [<https://perma.cc/84B6-73N3>] (finding the percent of mental health screenings completed using an approved tool increased from 1% to 74%).

258. Memorandum from Claudia Schlosberg to D.C. EPSDT/HealthCheck Providers, *supra* note 254.

259. *Id.*

260. The current reimbursement rate for developmental and behavioral screenings (CPT code 96110) is \$8.65. Providers are allowed to submit claims for 2 screens per well-child visit. *Medical Fee Schedule*, D.C. MEDICAID, https://www.dc-medicaid.com/dcwebportal/nonsecure/getFeeSchedule?filename=Medical_Fee_Schedule_Current.csv [<https://perma.cc/ME6C-8SFU>].

261. 2016 *Update*, *supra* note 254, at 1. These numbers are based on data from the DC Collaborative for Mental Health in Pediatric Primary Care. According to the District of Columbia's Department of Health Care Finance, the number of screens billed to DC Medicaid increased from 4,632 to 20,728 during the same time period. Memorandum from Claudia Schlosberg, Senior Deputy Dir. & State Medicaid Dir., to D.C. Medicaid EPSDT/HealthCheck Providers, National Children's Mental Health Awareness Week and Mental Health Screening in Pediatric Primary Care, Transmittal #16-17 (May 24, 2016), http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DG852345_KT0000002801_1.pdf [<https://perma.cc/4UQ9-G5CX>]. Assuming one screen per child, this translates into an increase in screening rates from approximately 5 percent in 2013 to 22.8 percent in 2015. In FY 2013, the number of children enrolled in D.C. Medicaid/CHIP was approximately 101,000. *FY 2013 Number of Children Ever Enrolled in Medicaid and Chip*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/chip/downloads/fy-2013-childrens-ever-enrolled-report.pdf> [<https://perma.cc/B4GZ-K58C>]. In FY 2015, the number of children enrolled in D.C. Medicaid/CHIP was approximately 100,000. *FY 2015 Number of Children Ever Enrolled in Medicaid and Chip*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/chip/downloads/fy-2015-childrens-enrollment-report.pdf> [<https://perma.cc/LWC6-LFZN>].

approach of bringing health and legal advocates together to identify challenges in the examination room and collaborate to remove those legal and policy barriers to health.

An interdisciplinary coalition in Connecticut also had a similar impact. The Connecticut Department of Social Services convened a task force comprised of experts from diverse disciplines, such as physicians and lawyers from the Connecticut Center for Children's Advocacy Medical-Legal Partnership Project, to review behavioral health regulations and make recommendations about screening, treatment and reimbursement protocols.²⁶² Drawing on the work of the task force, the Connecticut legislature drafted the Connecticut Behavioral Health Plan for Children, with a goal that "[a]ll children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services."²⁶³ Moreover, Connecticut's Medicaid agency changed the state's billing procedures to require that providers use a standardized tool and include a modifier (indicating whether the screen was positive or negative) to be reimbursed for developmental or behavioral health screenings.²⁶⁴ The MLP played a critical role in providing the "'patient to policy' perspective that may be missed in public health approaches more divorced from the clinical setting."²⁶⁵

In New Mexico, an interdisciplinary, public-private coalition housed at the University of New Mexico's Health Sciences Center (the medical center institutional partner of the MLA), is also tackling the gap in early identification of trauma and mental health needs. The J. Paul Taylor Early Childhood Task Force is made up of stakeholders from the public and private sectors who are working to develop policies to provide for the early identification and treatment of trauma and mental health among the state's children,²⁶⁶ including physician, attorney, and student representatives from the MLA. Created in 2013 by the New Mexico legislature to memorialize the work of Representative J. Paul Taylor, a life-long advocate of coordinated systems of care for children, the Task Force aims to create

262. Lisa Chedekel, Study Pushes Early Identification of Kids' Mental Health Problems, CONN. HEALTH I-TEAM (September 14, 2012), http://c-hit.org/2012/09/14/study_pushes_early_identification_of_kids_mental_health_problems [<https://perma.cc/P66V-JEJ4>].

263. *Connecticut Children's Behavioral Health Plan*, CHILD HEALTH & DEV. INST. CONN. 13 (Oct. 1, 2014), http://www.plan4children.org/wp-content/uploads/2014/10/CBH_PLAN_FINAL-2_.pdf [<https://perma.cc/F5XQ-UDA9>].

264. *Provider Bulletin 2014-43: Developmental and Behavioral Health Screens in Primary*, CONN. MED. ASSISTANCE PROGRAM (Jul. 2014), http://www.huskyhealthct.org/providers/provider_postings/PB%202014-43%20Developmental%20and%20Behavioral%20Health%20Screens.pdf [<https://perma.cc/8R4W-QR5D>].

265. Tobin Tyler et al., *supra* note 14, at 236.

266. H.M. 75, 51st Leg., 1st Sess. (N.M. 2013).

an early childhood system of behavioral healthcare that involves the prevention and identification of childhood maltreatment and other forms of trauma.²⁶⁷ With the explicit recognition of high rates of trauma among New Mexico's children and an understanding that early childhood experiences ultimately shape an individual's health, education, and socio-economic status, the Task Force seeks to connect at-risk children with the required mental health services support to stymie the enormous social and financial costs stemming from the failure to improve outcomes for these children.²⁶⁸ The Task Force also has a core mission related to the advancement of Medicaid EPSDT policy and practice through its founding principle that primary care providers—who, with the rights tools, can identify these issues, provide relevant diagnoses, and make recommendations for treatment—must play a critical role in the development of a comprehensive prevention, intervention, and treatment plan to target at-risk families.²⁶⁹

Reflecting the MLP framework, the Task Force explicitly aims to build bridges across disciplines, serving as a collaborative force for diverse early childhood development stakeholders.²⁷⁰ Child-serving systems often operate in silos, despite their explicit collaborative policy goals.²⁷¹ The Task Force seeks to bring representatives from these systems, including on-the-ground providers, together to enrich the policy development process with their diverse perspectives. This approach reflects the inter-disciplinary values that the UNM Health Sciences Center also brings to the MLA and its problem-solving approaches on behalf of MLA patients. The Task Force's membership typically includes representatives from the infant mental health, early childhood development, mental health, medical, social service, academic research, public education, disability, and child welfare systems and provider communities.²⁷² A dynamic and growing body, the membership of the Task Force has expanded to include, for example, state legislative finance committee staff, representatives from managed healthcare organizations, and the medical assistance division of the Human Services Department that oversees Medicaid for the state, providing an opportunity for analysis of the unmet potential of Medicaid EPSDT well child checks.²⁷³

Moreover, the Task Force provides an important platform for physicians and

267. *Id.*

268. *Id.*

269. *Id.*

270. *Id.*

271. See, e.g., Yael Cannon, *There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children*, 61 DEPAUL L. REV. 1049, 1051–52 (2011).

272. H.M. 75, 51st Leg., 1st Sess. (N.M. 2013).

273. S.M. 5, 51st Leg., 2d Sess., (N.M. 2014); H.M. 13, 51st Leg., 2d Sess., (N.M. 2014). The New Mexico legislature specifically called on the Task Force to engage legal experts, which is how I became its co-chair, along with Tara Ford, co-founder of a children's legal advocacy organization, Pegasus Legal Services for Children, in 2015. H.M. 47, 52d Leg., 1st Sess. (N.M. 2015); S.M. 69, 52d Leg., 1st Sess. (N.M. 2015).

attorneys to engage collaboratively with policymakers, a core tenet of MLP impact. The Task Force has the imprimatur of the state legislature, which has reconvened the Task Force annually since its creation, and includes representatives from government agencies like the state child welfare and education departments, providing MLA representatives and other non-governmental stakeholders an important forum to engage with the various branches of state government. The legislature charged the Task Force with developing a process for identification of the broad spectrum of underserved at-risk infants and young children in the state.²⁷⁴ Because three-quarters of New Mexican children qualify for Medicaid and all of them are entitled to well child checks, Medicaid EPSDT mental health screenings can reach a significant portion of the state's children. In 2014, the Task Force sought to advance policy to fulfill the promise of Medicaid EPSDT as an identification tool for needed mental health services for traumatized children. The Task Force issued a comprehensive report highlighting the national ACEs research and its screening framework as a means for understanding the prevalence of childhood trauma and its lifelong impact.²⁷⁵ The report recommended that Medicaid managed care organizations and their contracts with the state include coverage of ACE questions as part of Medicaid EPSDT well child checks in order to promote early risk-factor identification.

In 2014 and 2015, the Task Force worked with legislators to introduce bills to require that healthcare professionals providing Medicaid EPSDT services screen patients for ACEs and refer for necessary mental health services those children identified as having experienced at least two ACEs.²⁷⁶ By incorporating the ACEs framework into the Medicaid EPSDT well child check and adding other forms of trauma such as homelessness and persistent poverty to the list of ACEs,²⁷⁷ the Task Force hoped to fulfill the potential of Medicaid EPSDT to provide an opportunity for screening and identification of trauma and related mental health needs and referrals for medically necessary services. Ultimately, a Fiscal Impact Report by legislative staffers suggested that the legislation would have a significant fiscal impact, and it did not become law.²⁷⁸

274. S.M. 5, 51st Leg., 2d Sess., (N.M. 2014); H.M. 13, 51st Leg., 2d Sess., (N.M. 2014).

275. *J. Paul Taylor Early Childhood Task Force: Report 2014*, J. PAUL TAYLOR EARLY CHILDHOOD TASKFORCE (2014), <https://www.nmaeyc.org/sites/default/files/files/JPT%20Final%20REPORT%2012-04-14.pdf> [<https://perma.cc/NR2Y-9V63>].

276. Adverse Childhood Event Screening and Referrals, S.B. 73, 51st Leg., 2d Sess. (N.M. 2014), <https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legType=B&legNo=73&year=14> [<https://perma.cc/HV83-32QD>]; HSD Child Screening, S.B. 244, 52d Leg. 1st Sess. (N.M. 2015), <https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legType=B&legNo=244&year=15> [<https://perma.cc/T24R-34YB>].

277. S.B. 73, 51st Leg., 2d Sess. (N.M. 2014).

278. LEGISLATIVE FIN. COMM., FISCAL IMPACT REPORT, S.B. 244/a, 52d Leg., 1st Sess. (N.M. 2015), <https://www.nmlegis.gov/Sessions/15%20Regular/firs/SB0244.PDF> [<https://perma.cc/PSQ9->

The Task Force tried a different in approach in 2016, attempting to pass legislation to effectuate the Medicaid EPSDT mental health screening components of federal law at the state level through an approach similar to the one promulgated by Massachusetts, through which providers would be required to include comprehensive behavioral, substance use, and social-emotional development assessments as part of each Medicaid EPSDT well child check.²⁷⁹ Providers would need to use an evidence-based, approved screening tool to ask age-appropriate questions and to create a schedule recording the services provided to each recipient as a prerequisite for reimbursement.²⁸⁰ The bill addressed some of the concerns that primary care providers have raised locally and nationally about a lack of access to evidence-based mental health screening tools and to the training needed to use them effectively.²⁸¹ For example, the bill directed the state's Human Services Department to create a program to train primary care and behavioral health service providers for individuals under five-years old on screening, access to medically-necessary services, and documenting service needs.²⁸² Bills developed by the Task Force in partnership with legislators have also called for the collection of data on completed mental health and trauma screenings in Medicaid EPSDT visits and referrals resulting from those screens.²⁸³

While these legislative efforts have not yet succeeded, they have educated the legislature about unmet needs and set the stage for further policy discussions to improve the trajectory for at-risk children. A number of Task Force members are now exploring further policy development opportunities in this area with Envision New Mexico, a department of the UNM Health Sciences Center that trains professionals to improve the delivery of quality healthcare for children.²⁸⁴ Through a partnership with the national Alliance for Early Success, Envision New Mexico is studying the "barriers, opportunities, current practices, policy changes, gaps in care, and benefits to New Mexico in implementing socio-emotional screening for young children from birth to age 5."²⁸⁵ These efforts can provide a platform for physicians and other stakeholders to have a voice in articulating the barriers to implementation of the Medicaid EPSDT requirement of mental health screening in well child checks. Such initiatives can trigger discussions to address physician

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279. S.B. 24, 52d Leg., 2d Sess. (N.M. 2016), <https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legType=B&legNo=24&year=16> [https://perma.cc/5A85-LPKS].

280. *Id.*

281. *See supra* Part II.

282. S.B. 24, 52d Leg., 2d Sess. (N.M. 2016).

283. S.B. 244, 52d Leg., 1st Sess. (N.M. 2015); S.B. 24, 52d Leg., 2d Sess. (N.M. 2016).

284. *About Envision*, ENVISION N.M., <http://envisionnm.unm.edu/index.php/about> [https://perma.cc/7ZK6-6NYK].

285. *See About Us*, ALLIANCE FOR EARLY SUCCESS, <http://earlysuccess.org/about-us>. The initiative is beginning with focus groups to better understand the relevant issues. *See* Univ. of N.M. Health Scis. Ctr., Consent Cover Letter for Focus Group Early Success-NM (on file with author).

concerns raised locally and nationally about Medicaid reimbursement rates, limited time and competing priorities in well child checks, and a scarcity of children's mental health providers to follow through on referrals, especially in more rural areas.

Inter-disciplinary coalitions like the J. Paul Taylor Task Force can also consider as next steps policy developments to remove some of these barriers.²⁸⁶ For example, advocacy at the federal level could try to promote more detailed regulations or policy guidance from the U.S. Department of Health and Human Services (or legislation from Congress if the political will was there) to require states to collect data to show that comprehensive well-child checks are occurring and to provide training and evidence-based screening tools to primary care physicians to effectuate mental health screening as part of those doctor's appointments. Advocacy at the state level could push for funding through state Medicaid agencies to support the collection of data on mental health screening and referrals for services, provision of training and screening tools to physicians, the development of mental health services for children in certain communities where the services are scarce, and financial incentives for primary care physicians to complete mental health screenings as part of their well child checks, a policy approach that has been adopted in some states.²⁸⁷ Increases in reimbursements for well child checks would allow doctors to spend more time with their patients, and learn about their trauma histories and mental health needs. All of these ideas have been generated in robust discussions among the diverse public and private stakeholders who comprise the Task Force, which has mobilized physicians and attorneys from within the MLA and from other health and legal partners, as well as many other inter-disciplinary stakeholders, to thoughtfully inform policymakers as they seek to improve the lives of New Mexico's children and families. Families like Selena's can only benefit from the medical and legal professions mobilizing through research, coalition-building, and other engagement with government stakeholders to spur policy change as a means of achieving improved health and mental health outcomes for children who have suffered trauma.

CONCLUSION

Selena deserves a chance to live a healthy life. Without fault, she experienced significant trauma at a very early age. As Selena enters her teen years, identification of her mental health needs can open the door to provision of the services she and her family need to set her on a path towards improved mental

286. H.M. 75, 51st Leg., 1st Sess. (N.M. 2013).

287. For a map detailing which of the 50 states (plus D.C.) pay an additional fee to providers for conducting developmental screenings, see *EPSDT Resources to Improve Medicaid for Children and Adolescents*,

NAT'L ACAD. STATE HEALTH POL'Y (December 2013), <http://www.nashp.org/resources-improve-medicaid-children-and-adolescents> [<https://perma.cc/YKP3-AJT6>].

health and ultimately improved overall health. Even earlier identification and intervention as a younger child could have helped to steer her towards improved mental health and overall health earlier. Federal law provides an optimum structure for this early identification, a structure that is already supposed to be in place each time one of the millions of children enrolled in Medicaid visits the doctor for a well child check.

Without assurance that children are receiving their required mental health screens when they visit the doctor, however, we will continue to see children like Selena travel a path from childhood trauma to poor health. We will also see them confront poor legal outcomes like those experienced by the juvenile offenders in New Mexico who had rates of trauma in early childhood that are literally off the national ACEs study charts.

Medical-legal partnerships provide an important multi-level paradigm for change that can—through patient advocacy, institutional transformation, and policy change—inform future efforts to address the failure to ensure implementation of this key provision of children’s Medicaid law. First, in the examination room, pediatric providers can screen children comprehensively whenever possible and identify children with unmet health, mental health, and legal needs. They can collaborate with legal services attorneys to ensure that families are connected with the requisite services. When they see problematic patterns and have law partners who can bring impact litigation, their stories and expertise should inform those larger legal strategies.

Building on these advocacy efforts on behalf of individual patients and groups of patients, lawyers and physicians should collaborate to transform their respective institutions to take interdisciplinary approaches to problem identification and solving. If we educate the next generation of attorneys, physicians, and other healthcare professionals through this framework, our impact will be even more transformative; future leaders in law and medicine will enter their practices armed with a more holistic, collaborative, and upstream approach to helping the most marginalized among us. The next generation of leaders in law and medicine should be trained to understand trauma and its implications and the Medicaid system’s structures for early intervention as they prepare to play a role in developing improved health care practices and policies. These efforts can change the life trajectory for traumatized children.

The implications of this type of culture shift are highly promising. When physicians screen holistically for mental health and developmental needs, as well as for social determinants of health in the form of legal barriers and lawyers start thinking about the implications of legal challenges for health and well-being,²⁸⁸ we will have come out of our silos and realized that our institutions, both meant to

288. Wettach, *supra* note 10, at 312 (“Working in a partnership also gives clinic students an understanding of how the legal problems faced by a child and his family are interrelated with other issues affecting the child’s overall well-being.”)

“heal” through “care,” can achieve better health and justice if we work together. We can begin to speak the same language, translating medical information into legal standards, and injustices into health inequities, and create a shared culture of advocacy.²⁸⁹ After all, we are serving the same families, families like Selena’s, who can benefit from our partnership. Together, we can identify the needs of children like Selena early and mobilize collaboratively to help them obtain needed services.

Physicians and attorneys can go beyond transformations to healthcare and legal institutions and mobilize collaboratively in pursuit of broader policy change. Through the recognition of patterns in the examination room and the courthouse that are representative of policy failures, participation in research efforts to collect and analyze data to educate policymakers about policy problems, and engagement in local, state, and national coalitions to identify gaps and pursue policy solutions, physicians and attorneys can serve as catalysts for policy change, an important MLP response mechanism towards broader population health.²⁹⁰ Lawyers and doctors, and their nursing, behavioral health, and public health partners, should conduct research into the local, state, and national dimensions of childhood trauma—and its costly outcomes—to persuasively awaken policymakers to the problem and its nuances in particular communities. Finally, physicians and attorneys should come together with stakeholders from across disciplines and across the public and private sectors to develop thoughtful policies based on shared values, such as policies that remove barriers for patients and physicians to implementation of Medicaid EPSDT’s well-child check mental health screening requirements.

The efforts of the MLA, the Georgetown University Health Justice Alliance, and other health provider/attorney collaborations show that mobilizing towards policy change is an important response for our professions, allowing us to practice law and medicine “at the health care and community levels”²⁹¹ with inextricably intertwined goals of health and justice. MLPs can harness their collective experiences with patients and their holistic professional expertise to empower health and legal providers to “shine a spotlight on policy failures” to address social determinants of health.²⁹² Lawyers can help doctors and other healthcare providers become educated patient advocates, who can then enter the political arena in order

289. *Id.* at 311 (noting that MLPs benefit law students because they help them to develop the ability to translate medical charts into legal standards); Ellen M. Lawton, *Medical-Legal Partnerships: From Surgery to Prevention?*, MGMT. INFO. EXCHANGE J., Spring 2007, at 37, 40 (“Learning activities in the clinical setting are distinct from those in the legal setting, and part of creating a culture of advocacy entails adapting training to the medical model.”).

290. See Tobin Tyler et al., *supra* note 14, at 240–45 (discussing the importance of enforcement of legal rights for the health of individuals and populations and MLP as community health promotion and a forum for research and evaluation).

291. Tobin Tyler et al., *supra* note 14, at 237.

292. Tobin Tyler, *supra* note 14, at 237.

to correct these deficiencies.²⁹³ Armed with concrete expertise and informed by their interprofessional collaboration, lawyers and healthcare providers can submit testimony before legislative bodies,²⁹⁴ ensure compliance with existing laws and regulations,²⁹⁵ draft proposed regulations,²⁹⁶ work with professional lobbyists,²⁹⁷ and garner public support for reform through the media.²⁹⁸ The MLP movement, growing in size and scope across the nation, should harness physicians, nurses, other healthcare providers, and attorneys to advocate for policy change at the local, state, and federal level to improve outcomes for children with mental health needs, including consideration of how Medicaid EPSDT law and regulations can be improved to better improve lifelong outcomes for children with mental health needs.²⁹⁹

In 1966, Dr. Martin Luther King, Jr. asserted that “of all the forms of inequality, injustice in health is the most shocking and inhumane.”³⁰⁰ Inequities in social determinants of health, such as those connected to the trauma suffered by Selena and the challenges faced by her mother and aunt, are both initiated and institutionalized by policies and systems outside the realm of medicine, but contribute greatly to “pervasive and persistent” health disparities.³⁰¹ Health and justice cannot be divorced, and medicine and law should come together as professions to improve the lives of the most disenfranchised among us, including children who have suffered childhood trauma. In sum, we need a movement of current and future leaders in law, medicine, and policy to propel implementation of the vision that President Johnson and Congress articulated fifty years ago. The next time Selena visits the doctor, she should receive a mental health check-up too.

293. Carmean, *supra* note 179, at 511.

294. E.g., Sandel et al., *supra* note 13, at 1702 (describing the Boston MLP’s success in testifying before the Massachusetts’s Department of Public Utilities regarding proposed changes to the medical documentation requirements for utility protection benefits).

295. E.g., Daniel Atkins et al., *Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy*, 35 J. LEGAL MED. 195, 207 (2014) (citing HELP: MLP attorney success in “correcting a systematic failure by the local welfare office that was providing notices to non-English-speaking benefit recipients in English”).

296. Robert Pettignano et al., *The Health Law Partnership: A Medical-Legal Partnership Strategically Designed to Provide a Coordinated Approach to Public Health Legal Services, Education, Advocacy, Education, Research, and Scholarship*, 35 J. LEGAL MED. 57, 75 (2014).

297. *Id.*

298. Paul et al., *supra* note 151, at 304, 305.

299. While changes to federal law and regulations are outside the scope of this article, more research is needed on those possibilities, the barriers to such federal policy change, and ways to address those barriers (questions for a future article).

300. *Dr. Martin Luther King on Health Care Injustice*, PHYSICIANS NAT’L HEALTH PROGRAM (October 14, 2014), <http://www.pnhp.org/news/2014/october/dr-martin-luther-king-on-health-care-injustice> [<https://perma.cc/E6FV-Q8NA>].

301. See Laura K. Brennan Ramirez et. al., *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*, CTRS. DISEASE CONTROL & PREVENTION 4 (2008), <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf> [<https://perma.cc/MK58-QZRQ>].

